



# O&G

MAGAZINE

# LANGUAGE

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Coloured AUSLAN signs spell out 'respect'

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# From the President



**Dr Benjamin Bopp**  
President

This issue of *O&G Magazine* focuses on Language – spoken, written and unspoken – its history and contemporary challenges.

Language, like our College, is always evolving and responding to the influences of changing needs, technologies, and expectations.

Topics range from the origins of medical terminology to the description of pain and the importance of culturally appropriate and respectful language.

Not long ago, growth-restricted babies were growth ‘retarded’, but we still have lots of language failures – ‘failure’ to progress, ‘failed’ induction, ovarian ‘failure’, all assuming that we’re beyond an ‘incompetent’ cervix.

This very digestible issue also includes culinary words used in pathology, ‘problematic’ words, and you may be swayed by revelations about body language.

Thank you to the team who have contributed, edited, and collated this issue of *O&G Magazine*.

By the time of publication, we will have a new, Twelfth RANZCOG Council and Board and we acknowledge and thank our outgoing President.

Dr Vijay Roach has provided three years of tireless hard work, passionate advocacy, and determined leadership for our College during probably the most complex time in its history.

I’m indebted to Vijay as a fellow Board member and friend who, with the other Past Presidents and many members, I will be reaching out to for guidance and advice over the next two years.

To the numerous colleagues who have served the College at Committee, Council and Board level but who are now taking a well-deserved break, thank you!

The pro bono contribution of our membership is the backbone of College work.

Your Federal College Council has 22 elected representatives, 13 of whom are new to the role and currently four of the seven elected board members will also be serving their first term.

18 of 24 Federal RANZCOG Councillors and five of nine Board members are women. This is a time of considerable renewal.

Hopefully as borders reopen, we can meet again, regularly in Melbourne at our new College Place and all members can gather for social and educational events.

2019 seems a century ago!

This Council term will consolidate RANZCOG’s new ways of doing business – physically, virtually, and politically and we will be listening closely to our Fellows, Diplomates, and trainees to help address their concerns.

We will prioritise advocacy issues where RANZCOG is one of few voices available to support and advance the needs of our membership in the women’s health space.

The origin of many medical terms is Latin, for which there is a famous rhyme known to its long-suffering students:

*Latin is a dead language,  
Dead as dead can be  
First it killed the Romans  
Now it is killing me!*

To paraphrase Freidrich Nietzsche; whatever doesn’t kill you makes you stronger!

An unfortunately applicable sentiment during these challenging world times.

To you and your families, wherever they may be, have a safe, happy and healthy summer.

# From the CEO



**Vase Jovanoska**  
Chief Executive Officer

Here we are at the end of another year, how time has flown! It feels like it was 2020 not long ago and we were in the thick of a pandemic. But we are still experiencing the prolonged existence of COVID19 and trying hard to remain positive that life will soon resemble a pre-covid state or at least, afford us the opportunity to meet and engage with our peers and colleagues more consistently once again.

At RANZCOG, we have officially commenced the Twelfth RANZCOG Board and Council term, and I extend a warm welcome to our new members and those who are continuing on from the 11th Board and Council. In particular, I would like to welcome new College President, Dr Benjamin Bopp, to his first issue of *O&G Magazine*. I look forward to working with Ben and our new Board and Council over the next two years, to continue to advance our important work in women's health.

As 2021 draws to a close, I would firstly like to extend my appreciation and acknowledgement to our dedicated members, trainees and staff for their hard work on College business throughout 2021. It remained no small feat to maintain operational effectiveness and efficiency whilst continuing to bounce in and out of lockdowns throughout the year.

Whilst we are all excited about the festive season, many of our trainees are preparing for their upcoming FARNZCOG and DRANZCOG exams at the end of 2021 and beginning of 2022. We wish you all the best for your assessments and know the amount of work that you have put into getting this far already.

This year, the College embarked on important work in the wellbeing space with the release of a widely distributed Bullying, Discrimination and Harassment Survey. The survey was circulated to members, trainees, and staff with the intention of capturing the culture and environments of workplaces that our community work in. The deidentified data will be reviewed by an independent Advisory Working Group and recommendations passed down to RANZCOG in order to help us drive and advocate for the wellbeing of our members, trainees and staff across Australia and New Zealand. We hope to release the report in early 2022.

Looking ahead to 2022, we look forward to engaging with our members on the College's 2022–2025 Strategic Plan. A draft plan will be circulated to the membership for consultation and review, and we encourage you to provide feedback that will help shape our strategic direction for the next three years.

Finally, I would like to wish you all a safe and happy holiday season, wherever you are and whatever your plans may be. You have worked incredibly hard this year and we can all be proud of the work we have done for the communities, and their families, that we serve.

# LEADERS FOCUS



**Dr Nisha Khot**  
**MBBS, MD, FRCOG, AFRACMA, FRANZCOG**

This feature sees Dr Nisha Khot in conversation with women's health leaders in a broad range of leadership positions. We hope you find this an interesting and inspiring read.

Join the conversation on Twitter

#CelebratingLeadership @RANZCOG @Nishaobgyn

## Prof Caroline de Costa FRANZCOG

As I hold the ultrasound probe to check a fetal presentation in the antenatal clinic, I am reminded that when Prof Caroline de Costa started her career in O&G, ultrasound was not available to perform this simple task that we take for granted today. Prof de Costa's career has not only spanned great technological advances but has also spanned legal, ethical and societal change. She was the first woman to become Professor of O&G in Australia. She spearheaded the movement to make RU-486/mifepristone available in Australia. She is the current Editor-in-Chief of ANZJOG and has worked in Ireland, Papua New Guinea, Sydney and Far North Queensland. When our generation of Fellows speaks of standing on the shoulders of giants, Prof de Costa is that giant (although, you wouldn't guess it when you hear her soft voice). Prof de Costa has recently written a book, *The Women's Doc*, so I started my interview with asking her about the book.

### Can I start by asking you about your new book?

My book is called *The Women's Doc*, published by Allen and Unwin. It was their idea, not mine. They approached me and asked me to write an account of the things I had seen in the practice of obstetrics and gynaecology. Initially I said no, I didn't think there was anything interesting enough, but they persisted and asked if I would write a few short pieces. So I did that thinking they would agree that they weren't very interesting. But instead, they said they wanted a book. I worked with a wonderful editor who was very helpful when it came to choosing the right stories to include. It was launched in May this year and is now in bookstores everywhere. I haven't been able to do as many in-person publicity events owing to Covid, but am hoping to do some once restrictions ease.

### Could you please tell me about your days as a medical student?

I was born in Sydney and I started medical school in 1964 in Sydney. I was 16 at the time and wasn't sure I wanted to be a doctor. So I dropped out of medical school and for the next two and a half years, I travelled. I got a job on a Swedish merchant navy ship as a 'mess girl' mostly washing dishes. I got to go to North and South America and finally ended up in Europe. I then re-started medical school in Dublin, Ireland in 1967. The 1960s was a very heady time and I was involved in movements to improve access for women to reproductive healthcare although, at the time, I wouldn't have known to put it in those words. In Ireland particularly, there was a great need for contraception. Contraception was illegal at the time and it was frowned upon by the Church. There was definitely no abortion and sex was for married couples only! These were topics that were not talked about in polite company in Ireland (and indeed, in many other countries). In 1971, 47 of us women took the train from Dublin to Belfast in Northern Ireland. We planned to buy contraceptives and bring them back with us to Dublin, which was illegal. We announced that we were going to do this because we wanted to get caught to generate publicity. Incidents like this Contraceptive Train instance led to the founding of the Irish Family Planning Association.

At the same time, I became a single mother in my second year of medicine. I was aware that the situation for other women in that position in Ireland was terrible. Most women who got pregnant outside of marriage were hidden away and their babies were forcibly separated from them at birth. My family wasn't with me in Ireland at the time but they were supportive of my decisions. I was financially precarious since I was a student but I didn't feel any shame or stigma for being a single mother. I had a lot of friends who were really supportive, although none of us knew much about babies. We barely knew one end of a baby from the other! But everyone was willing to help me care for my baby and so we got through to the end of medical school. I took my baby to all the social events I was going to; he grew up as a very social person. It was a matter of organising time to look after him and also complete my studies.

### What led you to choose a career in O&G and how did you go about achieving this?

My experiences in my pre-clinical years and my early activism made me develop an interest in O&G. I felt that not only would I be able to provide care for



women but I would also be able to speak up about what women really needed from health services. On my first day in the labour ward as a medical student, I saw a breech birth. It was just a beautiful birth, the baby came out bawling, the mother was delighted to have a girl after three boys. That was it, I was hooked. I could not imagine doing anything other than O&G for the rest of my life.

By the time I finished medical school, I was married and had another son. My husband and I went to Papua New Guinea (PNG) for our internship and from there, we went back home to Sydney. We stayed with my parents for some time and both of us started as house officers. My husband completed his primary exam in surgery, and I did my primary exam in O&G. I applied for registrar jobs in O&G but was told very early that they didn't train women in O&G in Sydney in 1974. So we went back to Ireland and I started my O&G training. There were no women in training in Ireland either but the men were very supportive, in both the Rotunda and Coombe Hospitals in Dublin, where I did most of my training. They had known me as a medical student. I got a good training job. I worked in the NHS for my basic trainee years and then we went back to PNG where I was senior registrar at Port Moresby Hospital. We had wanted to stay in PNG, but this was very difficult for expatriates after PNG became independent. So we returned to Australia where I set up a practice in Sydney, a mixture of public VMO and private. I was fully qualified and a member of the new college, RACOG (Royal Australian College of Obstetrics and Gynaecology). Women just came pouring through the door because I was the only woman obstetrician. My male colleagues were very supportive in the Western Sydney hospitals I worked in, in both the public hospital and in private practice.

**It must have been very difficult and lonely being one of two or three women O&G specialists. What did you do to change this?**

There were a couple of other women O&Gs who had also trained overseas and were practicing in Sydney. We decided that we needed to get more women in O&G. We made a concerted effort to find women who were residents or medical students and had an interest in O&G. We encouraged them and mentored them and soon we had a number of women start O&G training and become fully qualified specialists. But it was not until the late 90s that we achieved gender parity amongst O&G trainees. So it took close to 20 years of gradual change to achieve parity. There was opposition from many male obstetricians at the time but there was also plenty of support. You can only get on to training programs, college committees etc if you have the support of those in decision-making positions. Without the support of the men (because it was men who were in these positions), we would not have achieved what we did, and it is important to acknowledge these men. Today we have more than 80% female trainees in the college. But it is equally important to think that anyone who wants to do O&G, is willing to put the hard yards in to training, should feel welcome and not feel like there are barriers to becoming a specialist O&G. We want to look at all barriers and remove them because I am not sure we would want to go to 100% female fellowship. It was not right to have 100% male fellowship either. Men and women should feel equally welcome in O&G. It is also important to remove barriers for women to gain leadership roles in obstetrics and gynaecology.



Prof Caroline de Costa.

Despite achieving gender parity amongst trainees in the 90s, we have only just this year achieved gender parity in leadership.

**What would you describe as the high points of your career; the moments that brought you the most joy?**

There are many high points but caring for women in pregnancy has to be the thing that brings the most joy. Especially caring for women who have had some difficulty in conceiving or have had obstetric disappointments, helping them negotiate the pregnancy and birth and have a successful outcome with a healthy baby is a truly joyous experience. This is probably why we all stay in obstetrics despite the challenges of long, unfriendly hours.

**What message do you have for medical students wanting a career in O&G?**

If you are interested in O&G, you need to look at the pros and cons, do an elective in O&G so you get a taste for it and then get some hands-on experience as a PGY 1–3. O&G allows you to have a variety of different options – a predominantly surgical practice, an academic career, a predominantly ultrasound practice, a medical/physician type practice – so there is a place for many different interests. It is a long road, but if you enjoy it, you should definitely give it a go.

**How did you come to be involved with abortion care in Australia?**

I moved to Far North Queensland in 2000 and realised that there was an urgent need for access to abortion for women in Queensland. I had not recognised the issues related to abortion care when

I was practicing in Sydney because, although the laws were draconian, there were clinics that provided a surgical abortion service and mostly, women could access them and also afford them. I was able to perform some abortions myself in my private practice. But Queensland was very different. I cared for a pregnant woman who had had severe preeclampsia in two of her previous pregnancies at 25–26 weeks. Both her children were alive but had significant disabilities and she was their primary carer. She became pregnant again but lived in a remote location where she had been refused a surgical abortion. At the time, there was no option of medical abortion in Australia because RU-486 was illegal. The inevitable happened and she developed severe preeclampsia at 25 weeks. She was too sick to be transferred so I did her emergency caesarean section in Cairns. Her baby died very soon after birth. When I saw her for her postnatal visit, she said how she would have preferred to have an early abortion instead of having a third operation and losing her baby at 25 weeks. And I had to agree with her. At that point, I felt I had to do something about abortion care for women in Queensland. I was able to use my position as a woman who was a professor of O&G to advocate for abortion. I had known of the existence of mifepristone but had to read up extensively about it to be able to speak with knowledge and authority. There were many people involved in the campaign to get mifepristone widely available and accessible to women all over Australia, including women members of Parliament who came together across party lines to make this possible. I am very proud to have been involved with this work and along the way, helping change the out-of-date abortion laws across Australia. The laws have now, finally, changed in all states and territories. There is still a lot of work to be done to destigmatise abortions and to make access equitable across rural and remote Australia, but we have come a long way since the 70s.

### **What has been your involvement with refugee women?**

While I was practicing in Sydney in the late 90s, I was asked by a refugee organisation if I would provide care for refugee women who were brought to Sydney and I was very happy to do this. I could look after these women as outpatients but when they had to be admitted to hospital either antenatally or for birth, it required a lot of negotiating with hospital administrators to allow them to birth in a public hospital when we knew that they could not afford to pay for it (and were not eligible for Medicare). This was my first experience of the inequities that refugee women faced.

Next, I got involved with an organisation called the National Justice Project writing reports about women in detention (onshore detention at that time) to recommend the best place for their care in pregnancy. I would be agitating for them to be released from detention, but I wasn't always terribly successful. In 2003, I was asked to go to Nauru to spend a week doing gynaecological surgery, mainly for Nauruan women but I also got to see women in the detention camp on Nauru. I became more and more concerned about these women and their children. I did a lot of lobbying for women to be transferred to Australia from Nauru for medical treatment. I also went to Darwin detention centre and saw the conditions in which the women were kept during pregnancy and postnatally. They were sending women back to Christmas Island from Darwin even though they clearly needed medical attention. Women were only

transferred from Christmas Island to Darwin at the last minute. They didn't speak English and their husbands and children were not allowed to accompany them to Australia, isolating them from their family when they were particularly vulnerable.

One of the women from Nauru, a Palestinian refugee, Dima, was brought to Cairns for her pregnancy care. Most women were transferred to Sydney or Brisbane and I have no idea why she was brought to Cairns instead. She was 37 weeks pregnant and had severe preeclampsia with a breech baby. She was initially told that her husband, Hani, could come with her but at the last minute, he was not allowed to board the flight. She had never been to Australia, and she had no support system here. I met her and became her support person. I never cared for her as her doctor, but I was with her when her son, Mohammed was born by caesarean section. With the help of lawyers, we were able to make sure that she and her son stayed in Cairns. Dima stayed in Cairns for a year supported by the refugee group in Cairns. The lawyers were trying to get the family together because her husband was still on Nauru. Suddenly, the immigration department moved her to North Adelaide where she was given accommodation but did not know anyone. It was much harder for us to help her while she was in Adelaide and she was cut off from the supports she had developed in Cairns. Hani was eventually brought to Adelaide where he was kept in detention. When he first arrived in Adelaide, he had a badly infected foot. I went to Adelaide and met him for the first time. He was on antibiotics but of course, they were useless because he really needed a surgical procedure. I made quite a fuss and was told that he had refused to go to hospital for treatment. On questioning, I found out that he was refusing to go because he would have to be handcuffed to two guards on both sides. He wasn't going to run away. His wife and son were in Adelaide. Yet, protocol meant that he had to be handcuffed when he was outside the detention centre. It was demeaning and unnecessary. After a lot of discussion with lawyers, the guards finally agreed to hold him by putting a hand on his shoulders so that he wouldn't be able to escape. Eventually, he got his foot fixed, but it really showed how every decision was designed to make refugees feel less than human.

At that time, I discovered that Dima and her family would never be allowed to settle in Australia. We looked at New Zealand, but this did not work out either. We then found out about a scheme whereby if we raised a certain amount of money and found a local sponsor, they could be resettled in Canada. My oldest son lives in Canada and is a Canadian citizen. He was very happy to be the sponsor. It took about 18 months to arrange, but at the end of that time, in October 2019, the Canadian government paid for Dima, Hani and Mohammed to travel by Air Canada to Toronto where my son was waiting to welcome them. It hasn't been easy for them since almost as soon as they got to Canada, the pandemic arrived. But they are now permanent residents, Mohammed starts school soon and they will become Canadian citizens next year. I feel really pleased that I could help make this possible.



**You were awarded the Member of the Order of Australia (AM) in 2014 which you returned in 2021. What prompted you to do this?**

I felt very honoured when I was awarded the Member of the Order of Australia (AM) in 2014 for my service to reproductive healthcare of women, in particular Aboriginal and immigrant women. I was not the only one who had done the work, it was always a team of people and I felt humbled by the offer. There were plenty of other people who were equally worthy of the award. One major reason for accepting the award was the fact that fewer women than men have received one of these awards, at all levels. The framed certificate hung on the wall of my Cairns office for seven years.

At the beginning of this year, I learned that Margaret Court was to be elevated to become a Companion of the Order of Australia (AC). She had already received the award of Officer (AO) in 2007 for her services to tennis. She was an excellent tennis player and had been rightfully recognised as such. But now she was to receive Australia's highest honour, intended for 'eminent achievement and merit of the highest degree in service to Australia or to humanity at large'.

But before 2007, and even more since, Margaret Court has made homophobic statements that are harmful to the people who are her targets. As the mother of a gay son, an absolutely wonderful person who does lots of good things all the time, I felt I had to take a stand. The granting of this second award sends a message from the Commonwealth Government of Australia that they are condoning and supporting her homophobic views. I was shocked and disgusted by this decision. I did not want to be associated in any way with these views and so I returned my AM to the Governor General.

**What do you see as future challenges in O&G?**

When I began in O&G, there was no ultrasound. You placed your hands on the mother's abdomen and made a diagnosis of presentation, size, liquor volume. Ultrasound revolutionised the information we could get before the baby was born and brought with it the possibility of checking for anomalies. We then developed prenatal testing for genetic disorders. Non-invasive prenatal testing is relatively new but has made a huge difference to how we test for genetic conditions. We also have carrier screening routinely available even before a pregnancy occurs.

Currently, we use these tests largely for medical reasons, but I can imagine a future where these tests will be developed to such an extent that the medical will start to border on the social implications for pregnancy. I envisage a whole bunch of ethically challenging decisions in the future.

**What lies ahead for you?**

I have decided to write crime fiction. It all started with the long days and nights of obstetric on call. You had to sit around in the tea room waiting for babies and invariably, you would find a book to read so you could stay awake. You had to find something that was page turning but not too intellectually challenging, and crime fiction fit the bill perfectly. I read lots of crime fiction. Over the years and I thought that's what I would like to do when I retire. I have published three crime fiction books and am looking forward to working on the next one.



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**Dr Marilla Druitt**  
FRANZCOG, MBBS, BMedSc

**MD:** One of my earliest introductions to the importance of words was a recommendation from an ornery old white male orthopaedic surgeon when I was a medical student. We must have been arguing about something and he recommended I read Dale Spender's *Man Made Language*. This Australian text was published in 1980 and describes how male writers shape patriarchal societies with language, and I think it is glorious that he told me (a cis white chick) to read it.

**AW:** Similar to Marilla, my interest in the dynamic nature and power of language was sparked as a student – in my case, as a teenager in high school. I was in year 12 and my school had introduced a new subject called 'English Language' into the school curriculum. I had never particularly enjoyed my English classes and the idea of analysing period texts in Literature didn't sound particularly enthralling, so I jumped at the opportunity to be a guinea pig student for this new subject. I fell in love with the subject, consuming every book I could find on the topic. I read Prof Kate Burridge's *Blooming English* from cover to cover, and I must admit when I heard that Dr John Schibeci had successfully commissioned a piece by Prof Burridge for inclusion in this issue, I had a bit of a fan-girl moment. I came to learn that the way my friends and I spoke, with all our 'likes' and 'you knows', was described by linguists as 'teen speak', and disappointingly that English had over 2000 expressions to refer to women in a sexually derogatory way.

However, the double-edged nature of language to both include and exclude, and empower and disempower people, had hit home several years earlier when my mum had been diagnosed with breast cancer. My mum was shocked by her cancer diagnosis and by the surgery required for treatment – a mastectomy. My mum's reaction was not helped by her doctor's description of the surgery, 'You'll be cut from here to here... don't think you'll be wearing a top like that anymore,' nor his lack of empathy at her reserved response, 'I don't know what you're worried about, it's just a useless gland.' A useless gland. These words rang in my mum's mind for months and years to come, causing more hurt than this doctor may have imagined. In medicine, the



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words we use when speaking to patients can make an enormous difference to their care experience and indeed their health outcomes. It is critical that we communicate with empathy and respect. Moreover, the words we use in the written form, such as in medical records and consent forms, are equally important, as I was reminded recently when seeing a patient for an abortion. Beyond being medical and legal documents, medical records and consent forms are a reflection of a patient's story and it is important that they are a true representation of their context and situation.

**MD:** More recently, my interest in language has been noting in my year 7's diary/planner. There is an inspirational quote for each week, and only five of 30 quotes were by women (feedback was provided)! Next was the gift of a lockdown book from a book club friend – *Cassandra Speaks: When Women are the storytellers, the Human Story Changes* by Elizabeth Lesser. I am now keeping a list of great quotes I come across, particularly to replace the war metaphors with those of kitchens and creating. Begone 'the scientists battling COVID in the lab' (there will be winners and losers), bring on 'working like beavers' (persistent, tenacious) or 'politicians recommending bleach is a recipe for disaster'.

**AW:** Like Marilla, my interest and passion for language continues to grow, along with my list of problematic words, phrases and grammar! Babies are 'born' not 'delivered'<sup>1</sup> [MD: pretty sure women were delivered from their biblical-style suffering...], people are not inherently 'vulnerable' but oppressive structures and systematic exclusion may give rise to vulnerability,<sup>2</sup> and 'ATSI' is never an acceptable acronym and is incredibly offensive to many Aboriginal and Torres Strait Islander People.<sup>3</sup> Over the last few years, I have worked in global maternal newborn health research and programs, predominantly with Pacific Island countries. There continues to be language used in global health and development that has strong colonial roots, reflecting historical and ongoing power imbalances. For example, the term 'capacity building' is often heralded as a project goal and is generally used to describe a 'one way' arrangement where a team from a high-income country builds the knowledge and

skills (capacity) of a local team in a low- or middle-income country. This language fails to recognise that the knowledge and skills of the non-local team are also 'being built' and undermines the expertise of the local team. It may be more respectful and representative to describe a reciprocal strengthening of capacity taking place through a process of co-learning. As I have demonstrated, global health tends to group and categorise countries, such as, 'low-, middle- or high-income', 'developing or developed' or 'Global North and South'.<sup>4</sup> These definitions are far from ideal and serve to reinforce the global dominance of the West. Narrowly defining countries based on their wealth and development acts to further marginalise, minimise and disregard the volumes of knowledge, expertise and experience within Indigenous communities. Whether working in global health or caring for patients in Australia and New Zealand, it is critical that we are aware of, and reflect upon, the language we use to avoid perpetuating colonial legacies associated with domination and subordination.

**MD/AW:** Respectful and inclusive language is vital for good healthcare, and the most appropriate language to use is, as always, an ongoing conversation. Language is a dynamic, organic part of human life, and we should expect and welcome language change as new perspectives emerge, and most importantly the voices of those who may be the subject of particular words and descriptions are listened to and heard. And as for whether this is a load of political correctness? As the sociologist DaShanne Stokes says, 'Political correctness' as 'over-sensitivity' is code for saying the privileged shouldn't have their unearned privileges questioned'.<sup>5</sup>

In bringing about this special issue of *O&G Magazine*, we want to take this opportunity to thank all the wonderful contributors who, through their writing, challenge us to reflect and reconsider the words we write, speak and think. It is important to note that there is so much more discussion to be had around language, especially from the perspectives of First Nations scholars, academics and orators – stay tuned for a language edition round 2. We would also like to acknowledge Lisa Westhaven, a previous *O&G Magazine* team member, who had the initial idea for this issue. Enjoy the collection of must-read books and articles provided by magazine contributors and readers that follow – a summer reading list perhaps?

We hope this issue generates discussion, and as people of science who seek the truth, we continue to rediscuss and reassess how best we use our language to provide safe and respectful healthcare and a society that works for all.

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## Reading list

### Books

- *All About Yves* by Yves Rees
- *Cassandra Speaks: When Women Are the Storytellers, the Human Story Changes* by Elizabeth Lesser
- *Forbidden Words* by Keith Allan and Kate Burridge
- *Man Made Language* by Dale Spender
- *Pain and Prejudice* by Gabrielle Jackson
- *The Dictionary of Lost Words* by Pip Williams
- *Unwell Women: A Journey through Medicine and Myth in a Man-Made World* by Elinor Cleghorn

### Articles

- *A pouch of Douglas by any other name* by Jane McCredie. [insightplus.mja.com.au/2021/36/a-pouch-of-douglas-by-any-other-name](https://insightplus.mja.com.au/2021/36/a-pouch-of-douglas-by-any-other-name).
- *Always bet on black (power)* by Chelsea Watego. [meanjin.com.au/essays/always-bet-on-black-power](https://meanjin.com.au/essays/always-bet-on-black-power).
- *Don't call me mister – call me doctor* by Samantha Pillay. [samanthapillay.com/dont-call-me-mister-call-me-doctor](https://samanthapillay.com/dont-call-me-mister-call-me-doctor).
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- *The power of words revisited* by Nicky Leap (Leap N. The power of words. *Nurs Times*. 1992;88(21):60-1. PMID: 1608762.)
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- *War Metaphors in Political Communication on Covid-19* by Eunice Castro Seixas. [www.frontiersin.org/articles/10.3389/fsoc.2020.583680/full](https://www.frontiersin.org/articles/10.3389/fsoc.2020.583680/full).
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# Choosing our words wisely: why language matters



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If we cast back to university, much time was spent carefully learning an entirely new vocabulary. As a country public school kid, Latin was certainly not part of my high school curriculum. Yet with time, painful repetition and effort, this new medical language of anatomy, physiology, pharmacology and histopathology became gradually familiar. At some point along the journey, we become unconsciously competent in this language as we write our notes, handover patients and refer to colleagues. This shared language that emerges amongst clinicians draws from medical terminology – ‘those technical, specific, standardised and precise words, terms and phrases that are used in medicine’<sup>1</sup> – but medical language is more than just scientific words. It is the application of these technical terms to construct a shared meaning with colleagues using phrases, jargon, acronyms and abbreviations, and expressions. This is perhaps most obvious in junior doctor training, when rotations between specialties demonstrate that the same abbreviations can have completely different meanings. An entirely different set of alarm bells start to ring internally when we are told about the hypertensive patient compared with the hypotensive one, and of course, this is informed by the broader patient context for the patient with preeclampsia compared with the one with a postpartum haemorrhage.

We have all become proficient in the specific syntax of this language and switch for the most part seamlessly. We speak differently for efficient handover of a full ward of patients or to explain complex health choices in plain language with our patients. However, there may also be times when this medical language starts to reflect and influence our stigmas, biases and depersonalisation, whether consciously or unconsciously. As Dr Bethany Boulton writes, there is an important, if subtle, difference between the ‘miscarriage in six’ and the ‘patient having a miscarriage in six.’<sup>20</sup> Unfortunately, the populations objectified and stereotyped in common

medical parlance may already be at increased risk of poorer health outcomes due to social disadvantages. Certain labels are weighted heavily with accompanying assumptions, like the ‘difficult patient,’ which may in fact better reflect the troubled clinician.<sup>2</sup> The way we speak to, about, and with patients and priority populations influences our understanding of the factors that drive vulnerability and risk, and therefore how we might better engage with addressing these inequities.

The COVID-19 pandemic has seen some words become overused to the point of losing meaning – the misuse of unprecedented is a personal bug bear. As we dial in to daily press conferences, we hear our political leaders and celebrity Chief Health Officers reflecting on the vulnerability of specific patient groups. The overuse of the word vulnerable tends to misplace and dispell more accurate recognition of the various social inequities that underlie this supposed vulnerability.<sup>3</sup> Certainly, some groups can be considered vulnerable because of physiological differences that increase risk, such as for pregnant women who are at higher risk of complications from COVID-19 compared with non-pregnant women of the same age.<sup>21</sup> But within this group, the risk is not equitably experienced if you consider the pregnant patient who is a front-line essential worker, in a casualised industry without access to sick leave, who is financially dependent on continuing to work in settings where they may be exposed to COVID-19, compared with the pregnant patient who is supported by their employer to work from home.

There is also a sense of disempowering inevitability that accompanies this use of the word vulnerable, and frequently this is joined by a blaming narrative, where a group’s poorer health is seen to be generated by their choices and behaviours.<sup>4</sup> This risks compromising our ability to provide safe care for individuals and limits our vision for change. For example, we cannot possibly address the complex interplay of social, biologic and environmental determinants that contribute to overlapping experiences of substance use, mental illness and addiction, if our language, practices and systems are stigmatising.<sup>5</sup>

Reducing entire ethnic groups to their vulnerabilities is a new kind of scientific racism,<sup>4</sup> and the overfocus on those experiencing these disparities renders invisible those groups responsible for, and who may benefit from, these inequities.<sup>6</sup> As we repeatedly witness differential outcomes from COVID-19 for First Nations and other ‘racially minoritised’ groups the world over,<sup>7,8</sup> failure to unpick the underlying causes of this ‘vulnerability’ is a missed opportunity to fundamentally address these systemic factors and Build Back Fairer.<sup>9</sup> In Australia last year we also saw firsthand the power of partnership, codesign, and Community Control,<sup>10</sup> terms which carry an entirely different set of empowering assumptions. The potentially increased risk of poorer outcomes from COVID-19 for Aboriginal and Torres Strait Islander peoples was recognised early by Community Leaders, based on a nuanced understanding of the



social determinants of health and the ways in which social disadvantage contributes to a higher burden of chronic disease, barriers to accessing healthcare, and increased risk factors for transmission, like large household size and poor housing infrastructure.<sup>3,11</sup> Ensuring Community Control and cultural governance are centred in pandemic response efforts leverages the strengths of closeness and connectedness within Communities and recognises that vaccines are but one vital tool that must be accompanied by broader improvements to health service access. As Aboriginal Health Worker, Ms Kylie Taylor of Hunter New England Local Health District, so aptly captures, 'We're not more at risk in COVID because we're Aboriginal or Torres Strait Islander or Pacific Islander, we're more at risk because our people have always been poorly serviced by the health system. Being colonised is the risk factor.'<sup>22</sup>

Despite the tangible implications for patient safety, this focus on language, cultural safety and inclusion may seem disconnected from our daily clinical work. There is sometimes an unspoken implication that preferences the successful proceduralist over the successful communicator. The experiences that matter to our patients, like feeling they have an opportunity to express their concerns,<sup>12</sup> may not always align with the enforced clinical priorities of our challenging workloads. It can also be confronting to apply labels like sexism, racism, or homophobia to our professional experiences and clinical institutions. For me, the power of an intersectional approach is in recognising that we can each have multiple axes of identity that simultaneously and cumulatively influence our perspectives and experiences.<sup>13,14</sup> This is less about apportioning blame or comparing privileged identities, but rather to create opportunities for reflexivity and to learn from marginalised voices while recognising the burden repeatedly imposed on the oppressed to serve as educators.<sup>15</sup>

Our relative power as clinicians creates a responsibility to identify avenues for enhancing the shared therapeutic alliance and supporting our patients. We know that racism diminishes all of us, and it is increasingly recognised as an independent social determinant of health.<sup>16,17</sup> We must listen when our colleagues tell us that internalised, interpersonal and institutionalised racism contribute to tangible negative health impacts.<sup>18</sup> Fostering inclusion and diversity within our health services is vital to ensuring we provide culturally safe and accessible care for our patients, but also underpins how we engage with each other as colleagues. I want to be part of a health system where we can all safely be our whole selves at work.

Ultimately, many of the practices that we would incorporate to provide gender-affirming and culturally safe care align with the broader principles of patient-centred care. Having expended so much effort in developing our skills in the science of medicine, it seems a shame to undermine this by failing at the art of medicine through ineffective communication. It costs me virtually nothing to approach patients free of assumptions, whether about their gender, sexuality, cultural identity or healthcare preferences. Yet subtle changes in language and communication can carry great significance for patient experiences and influence their future relationship with health services.<sup>19</sup> Choosing our words wisely is just the first step in fostering inclusion and is an opportunity for each of

us to influence cultural and system change. Like any other part of our practice, we may have moments of failure and error, especially where something is new. As with any clinical mistake, a sincere apology and a commitment to improve is surely the least we owe our patients as part of our collective commitment for empathetic care. We should similarly persevere and remind ourselves constantly to refocus on patient-centred care that is tailored to each unique individual, their partners, carers, family, and community.

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# Toku reo, toku ohoo

## My language, my awakening



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'Mairangi Mai! – Wake up tai Tokerau (Northland).'  
Kuia (female elder) Merimeri Penfold exclaimed 'our  
language and our marae are struggling'.<sup>1</sup>

At the beginning of the 1800s, te reo Māori was the predominant language of Aotearoa New Zealand. As English speakers arrived, te reo Māori speakers became less and less of the population. Actions that suppressed Māori culture also suppressed the valuing and understanding of the language. The evolving European education system in New Zealand soon turned its back on te reo Māori and took Māori children out of traditional Whare Wānanga (schools). Missionary schools and Native schools worked to educate Māori children in English and punished the use of te reo Māori.

As te reo Māori changed and faltered in Aotearoa with influence from English, a written version of the language arose and was used by both Māori and Europeans. One of the most prolific and harmful

examples of te reo Māori being misunderstood was the two versions of te Tiriti o Waitangi/Treaty of Waitangi first signed in 1840. The mistranslation of many words, and therefore the different understandings of what was agreed, still has effects to present day.

By the mid-1900s, te reo Māori was in danger of being lost completely. Māori-driven initiatives, such as Kōhunga reo and Kura Kaupapa, helped lead the resurgence of te reo Māori in education.<sup>2</sup> In 1987, te reo Māori was recognised as an official New Zealand language. Te reo Māori is now seen and heard in mainstream spaces, especially at all levels of education. Media, arts and many businesses have also started embracing and revitalising te reo Māori for everyday use.<sup>3</sup> This supports not only the rebuilding of te reo Māori understanding, but also te Ao Māori (the Māori worldview) and Māoritanga (Māori culture).

Linguists have long recognised language and culture as interwoven. Languages represent philosophies and social structure;<sup>4</sup> 'to learn [speak] a different language is to encounter a different logic, a different cadence, a different sequence of words, it prepares you to think differently'.<sup>5</sup>

In the 2018 New Zealand Census, 73% of Māori adults said that using te reo Māori in daily life was of some importance, with over 30% saying it was very important.<sup>6</sup> This importance was higher in wāhine Māori, showing the importance of te reo in obstetric and gynaecological medicine. Around half of Māori adults in this census could understand or speak words and phrases of te reo Māori. 89% of Māori adults also reported that it is important to be involved in things to do with Māori culture.

Communication is a key component in any society; as language develops, so too do unique cultural skills. This provides a sense of connection, ownership, and community. Like many indigenous languages, Te reo Māori and Māoritanga (Māori culture) are inseparably linked.

There have been many examples of health organisations recognising the importance of te reo Māori and Māoritanga to people's health. Hāpai Te Hauora and the Mental Health Foundation previously launched a campaign around the protective factors of te reo Māori and wellbeing.<sup>7-9</sup> Research has shown that confidence in te reo Māori and a connection to Māoritanga are linked to a lower risk of suicide indicators, such as isolation, in Māori youth.<sup>10</sup>

Cultural competence courses often aim to promote meaningful engagement with Māori patients, through appropriate language and interaction during a patient's care. RANZCOG is fortunate to have a relationship with the University of Otago's Māori/

Indigenous Health Institute (MIHI). MIHI provides a cultural competence course for all RANZCOG trainees and Fellows. The course teaches the Meihana model and the Hui process which are teaching tools grounded in Te Ao Māori. They have been especially adapted for RANZCOG by the MIHI team, which includes RANZCOG Fellow Dr Angela Beard. Participants have reported being easily able to apply these models within their clinical practice. The goal of the tools is to translate cultural competency principles into an approach that clinicians can use to improve their responsiveness to Māori clients and their whānau within existing clinical practices.

Learning to pronounce Māori words correctly is another way to connect with patients and shows respect for the language and the people.<sup>11</sup> This is a great place to start as a clinician, along with a simple greeting such as 'kia ora'.

MIHI, alongside Te Tumu of Otago University, have developed an app that supports learning te reo Māori that is relevant to the health sector.<sup>12</sup> Aki Hauora is an interactive app that teaches commonly used phrases as well as interactive games to be used with patients. MIHI believe that the use of te reo Māori in consultation provides the opportunity for deeper connection with patients and a greater understanding of their cultural needs. The app is also used throughout the Otago University Medical school with students to support their te reo Māori learning as they train.

Te Pou have also created a glossary 'Te Reo Hāpai' that includes new words in te reo for the mental health, addictions, and disability sectors.<sup>13</sup> Te Pou used information gathered from engagement with Māori to create a useful tool to support health professionals to embrace te reo Māori in their everyday practice.

It is important to acknowledge that everyone is on a journey with language, and that an openness to making mistakes and learning from them is vital. Much has been written around the importance of actively listening to people who have names you do not know how to pronounce, and the important step of simply asking how to pronounce their name.<sup>14,15</sup> Te reo Māori has regularly occurring sounds and spellings that may be daunting when first heard or read. Practicing these, and actively seeking chances to hear these sounds being said, can be a great way to build confidence for when you want to use them. And you can always clarify again if you are unsure.

Health professionals have varying levels of te reo skills and vocabulary. Being patient-led on when and how to best incorporate te reo Māori into conversations is a respectful and culturally safe practice and ensures there is an understanding of what the patient is comfortable with.

**He iti te mokoroa nāna te kahikatea i kakati**  
**Even the small can make a big impact on the big**

### Te reo pronunciation resources

- The Māori Language Commission: [www.tetaurawhiri.govt.nz](http://www.tetaurawhiri.govt.nz)
- The Ministry of Education: [tereomaori.tki.org.nz/Reo-Maori-resources/Ka-Mau-te-Wehi/Introduction-to-teaching-Te-Reo-Maori/Pronunciation-guide](http://tereomaori.tki.org.nz/Reo-Maori-resources/Ka-Mau-te-Wehi/Introduction-to-teaching-Te-Reo-Maori/Pronunciation-guide)
- Māori dictionary includes recordings of how to pronounce words in te reo: [maoridictionary.co.nz](http://maoridictionary.co.nz)

- A great YouTube video featuring Waka Huia and Jennifer Ward-Lealand and her journey learning te reo Māori: [www.youtube.com/watch?v=VmWeOF8WPQU](https://www.youtube.com/watch?v=VmWeOF8WPQU)

### Health professional te reo resources

- MIHI cultural competence course (RANZCOG members only): The course involves online learning, as well as a face-to-face hui, and assessment modules. If you are interested in enrolling in this course, or have further questions please get in touch with amber.philpott@otago.ac.nz
- Most DHBs offer a te reo Māori course, or access to te reo Māori courses run through local wananga.
- Te Reo Hāpai – A glossary of existing and new te reo Māori terms for use in the health, mental health, addiction, and disability sectors: [www.tereohapai.nz](http://www.tereohapai.nz)
- Aki Hauora app – University of Otago developed app with tools to help health professionals and students learn or become more familiar with Māori language used in healthcare: [www.healthnavigator.org.nz/apps/a/aki-hauora-app](http://www.healthnavigator.org.nz/apps/a/aki-hauora-app)

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# The SIMG journey: personal experiences



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Since 1945, when the first federal immigration portfolio was created, over 7.5 million people have settled here and Australia's overseas-born resident population is estimated to be about 30% of the total, as per the Australian Bureau of Statistics (ABS) data.

I've considered myself a global citizen for as long as I can remember; by birth I am of Pakistani origin, grew up in Africa, and migrated to Australia just after my MBBS/internship work. I do have a unique accent and am often asked where I am from. I do not take offence to this and feel that it is intended as a natural curiosity; mostly I turn this query around and say 'try and guess.' I am constantly amused at the answers, many significantly geographically remote from the reality!

I am proudly multilingual and often say, humour intended, 'I speak three languages and a bit of English'

Migrants' wellbeing and financial independence is strongly tied to their employment, education and English language proficiency.

I fondly remember my first day in the birthing suite as an eager medical student, feeling immediately – this is what I was destined to do longer term, this was my calling. As a generalist O&G, I have felt that passion has remained undiminished, despite the uphill-ness of some of my journeys and the hoops I have jumped through to get to where I am today.

My professional journey, in terms of settling into the Australian medical system, was a relatively comfortable one at the entry, probably because I migrated when I had just recently completed my medical degree, hence the Australian medical Council exam (1 & 2) were easily accomplished. Pre specialist days, one is more well-rounded in terms of knowledge, and all of my education had been English based. I had also passed USMLE 1 & 2 as a medical

student, and hence the pattern of the AMC was not daunting for me. I am a nerd at heart and joined various study groups based at Westmead library when I arrived in Australia, though there was not the benefit of the social media connection at that point, in 1995. I then did an observership at Canterbury Hospital prior to my AMC 2.

My personal journey has made me want to give back, so I have set up a private multidisciplinary team care service for women's health, and it is my pride that we have transitioned a number of observership positions for both medical and midwifery staff. Mentoring those that come behind us is so important to our team.

It can be isolating when you migrate to a new country, and forming the social connections and network I believe is critical, not only for one's mental health, but also for the practicalities of learning from others' experiences navigating access into, and survival in, the medical system. I also appreciate that there is a difference between the relatively young migrant that I was, coming from a system overseas where I was also at a junior level, so my transition was much kinder than if I was migrating at a stage where perhaps I was more set in my ways; used to being in a higher position of authority, and then having to assume a role which was midrange. Many consultants in their home country then function as either service registrars when they are trying to gain entry into the system or as provisional fellows when completing the recommended time prior to applying for an upgrade. This can be a double-edged sword because at a personal level, it can be hard coming from a totally different set up and adjusting into the work culture here, and getting accustomed with local practice and policies. Many times, unfortunately, there is less patience from the hospital end (due to workflow logistics) where there can be a perception that, especially at the beginning of their transition, there is less value because that clinician is needing more support and time to settle in.

Although there is so much similarity in obstetrics worldwide, the reality is that working at a busy tertiary service overseas, I had no doubt been exposed to a far wider variety of pathology and skill than my equivalent local Australian graduates. I had done an O&G term as part of my internship and was expected to suture perineums, actively manage the birthing unit with the senior team, and was exposed to far more theatre opportunities, even in my short time working there.

My biggest adjustment was in the counselling of women. I had been taught for years to confidently plan for the patient, and having worked within the logistics of super busy clinics and birthing unit, without a huge emphasis on providing options in the first instance, I needed to adapt to a different style. What I love most about practicing medicine in Australia is the increased time we are able to give women to discuss choices and options and work through, together, what would be the best

individualised management plan for them (especially as a consultant in private practice, it is now entirely my decision how long I want to spend in a consult). The mindset overseas (albeit more than two decades ago) was that patients mostly expect the doctor to tell them the management plan, and may be less comfortable to be asked to actively contribute to the decision making. It is ideal that women are in the driving seats of their health journeys; however, this is a complex space requiring culture changes in the community, but also the resources to support this.

Even now, when I care for migrant patients, they will often cut me short when I am trying to elaborate options of care and say 'you decide, I trust you and you know best', to which I then respond and say, 'I would like us to discuss more and for you to choose, but yes of course I will give you my opinion/recommendation'.

The ability to speak a language that the women understand cannot be underestimated in migrant health. At times, the relief on the faces of women and their families is so visible when you communicate with them, and the connection more instantly solid in terms of trust. I love these moments, because as healthcare providers, we are constantly striving for those that we care for to be at their most comfortable points on their path to health.

Diversity has been shown to be an asset for healthcare, and in general for any institution. Unfortunately, the more senior I became, as a woman of colour, I saw hardly anyone that looked like me in a position I could aspire to. I have been in countless forums of this sort, and I have been a constant catalyst for change in this space so that others behind us in the timeline will have different experiences.

International medical graduates (IMGs) contribute significantly to the wellbeing of women and their families in Australia. Inclusive work cultures are best, offering an empathetic support to the transition of such doctors. There is incredible talent, at times less obvious at the beginning, that blossoms as they get more confident and settled into the role expected of them.

My advice to IMGs would be to embrace change; the combination of what you bring to the table plus what you absorb in the local system can lead to an amazing version of yourself, do not be limited by who you feel can help you. I have, and continue to, learn a lot from the midwives I work with. I also feel our junior medical officers have so much to offer; the hierarchy can be limiting unless we believe we can teach and learn from everyone in the team.



**Dr Poonam Baskaran**  
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**Registrar in Obstetrics & Gynaecology**

I am Dr Poonam Baskaran and would love to share my story with you. I moved to Sydney six months after completing my postgraduate in O&G, all starry-eyed hoping to apply to RANZCOG and be accepted as a SIMG. My dreams came crashing when my application was rejected. From then started the struggle of deciding what path to take. The options were few and clear – to go back to India, choose to give up my career or to appear for the AMC exam and try to work as a registrar. I decided to give it a chance and see if I like working in the medical system here. I cleared the AMC part 1 and was fortunate to get an opportunity to work as an unaccredited registrar in O&G straight after. I was anxious about being in a surgical branch of medicine in a foreign country, but having completed all my formal education in English, I did not for once think language would be a barrier in my professional career. I must say though, Australia does speak English a bit differently. A few words and phrases did throw me off guard. Like for example, when a woman would say 'I went out with my girlfriend last evening', I would not understand if she meant she is in a same-sex relationship or just two friends catching up. And as I thought it was a bit offensive to ask directly, I would beat around the bush and get the information I was looking for. I have had to co-relate the actions to words when a colleague would say, 'I have to have a Wizz!' Or when they would ask patients especially, postoperatively, if they were passing water well. When I was working in emergency, I had to Google a few slang words like 'bloke', 'feeling crook', 'buggered', 'cactus', being a worrywart, having a 'vom' or a 'spew' to understand what the patients were trying to tell me. I do have a better understanding of what patients mean when they use these words and phrases today, but I wonder if I would ever incorporate them into my vocabulary. I speak three languages apart from English and that has helped me immensely in my



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communication, especially whilst working in Sydney, which has an increasingly multicultural demographic.

The work culture is also quite different in Australia. Understanding and aligning to the role of midwives in patient care and management was a very new concept for me. It is a beautiful equation and beneficial to patients, but of course, has its downsides. I did feel I was judged initially when the hospital staff would talk a bit slowly ensuring they speak clearly so that I understand, even before knowing my background. Today, I feel they were just trying to be accommodating in their way and being team players but that's not how I saw it at the time. Of course, the same people, once we got to know each other better, asked me how come I speak English so well? I had to educate them that the majority of the population in India from the metropolitan cities complete their formal education with English as their first language. I also come from a culture where elders are always addressed with a prefix or a suffix as a sign of respect. Addressing senior colleagues by their first name is another thing that took a while to get used to. I have also had some interesting advice from a few very well-meaning colleagues who advised me to ensure that I always have a shower after cooking and before getting to work, or use a good perfume to make sure I don't smell like spices and curry when I get to work. Although I was a bit frazzled by all of this initially, it is now not a concern at all. I have thoroughly enjoyed my journey of practicing medicine in Australia and can confidently say that if you have confidence in your knowledge and skill as a doctor, the barriers of culture, language, etc would not pull you down for long. It's about coming in with the right expectations and being willing to adapt, but at the same time stand your ground.

Migrants who have English as their first language may struggle less with language barriers as they settle here and explore various employment opportunities and access healthcare facilities for their family. While their counterparts from countries with English not being the first language may find these language barriers more confronting. I have encountered these scenarios way too often in my public and private practice.



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**Consultant urogynaecology & laparoscopic surgeon**  
**VMO Royal Prince Alfred Hospital,**  
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I moved to Australia from India in 2009. After attaining my RANZCOG fellowship, I completed my subspecialist urogynaecology training in 2019 in

national and international centres. All these training years exposed me to multiple patients with different cultural backgrounds and language differences where I would be consulting via interpreters to explain conditions and treatment options. Being multilingual and well versed in three different languages, I found that patients with an Indian background really felt at ease with my consultations and most likely to follow through the advice given.

The majority of my practice now deals with urogynaecological problems of prolapse and incontinence, more prevalent in older-age population and that section of immigrant patients who might not have had the opportunity to learn English which makes it difficult for them to access any health services. My practice regularly exposes me to people of various different ethnicities and cultural backgrounds. I was amazed when I recently got referral for Indian patients from an area more than 30km from my practice, even though there are lots of consultants with similar expertise and experience in between. I remember seeing a Punjabi patient who was so happy to see a consultant that can converse in her language during the consultation that she mentioned her concern of not understanding anything with her previous consults being done in English. This not only provokes anxiety related to attending a consultation but can lead to patients' reluctance to continue with follow up. At the end of my consult, when I decided to provide her with patient information sheets, I realised I didn't have any in any other language that would be more helpful to the patient. She hugged me and had tears in her eyes at the end of the consult, leaving me teary as well.

I endeavoured to develop some of my information leaflets in Hindi to better serve these patients. Over the following months, more and more patients followed that were highly excited to see a consultant with same-language background, reiterating the importance of culture and language in every community.

I remember as a part of the IUGA (International Urogynaecological Association) pelvic floor imaging special interest group I was tasked to translate patient information leaflets in Hindi and another colleague was asked to produce the Spanish version. The international community is well aware of the need to provide leaflets in different languages and we, at national level, need more work to make these RANZCOG information pamphlets available in different languages as well to help our immigrant population access healthcare more efficiently.

I am glad the College is very keen to highlight these issues of language barriers with this special issue, spreading awareness and developing strategies to help patients with a different first language than English, when it comes to providing healthcare.



# Interpreters: breaking down language barriers

**The Women's Language Services Team  
The Royal Women's Hospital, Vic**

Language is a tool of communication. Communication between two parties in the same language is complicated enough, let alone when it is conducted in more than one language, with multiple parties including an interpreter involved. An interpreter is a qualified professional who 'transfers a spoken or signed message from one language (the source language) into a spoken or signed message in another language (the target language) for the purpose of communication between people who do not share the same language.'<sup>1</sup> But the effectiveness of this communication process hinges on factors such as cross-cultural issues, interferences from third parties and role boundaries and perceptions. This article attempts to discuss these issues based on the day-to-day interpreting experience of a team of in-house hospital interpreters working in women's health.

The Royal Women's Hospital's Language Services team provides interpreting in more than 70 community languages. Fourteen of the most requested languages – Arabic, Mandarin, Vietnamese, Cantonese, Amharic, Greek, Urdu, Hindi, Oromo, Punjabi, Spanish, Tigrinya, Turkish and Japanese – are spoken by in-house accredited interpreters.

In satisfying the hospital's commitment to help patients effectively communicate with staff to make their own decisions with informed choices about their healthcare, the Language Services team tries to make their presence and work valuable for overcoming language barriers between patients (who speak little or no English) and health professionals.

## Cross-cultural communication

'Victoria is home to one of the most culturally diverse societies in the world, and is also among the fastest-growing and most diverse states in Australia.'<sup>2</sup> According to the 2016 census, almost 29% of Victorians were born overseas in over 200 countries, and nearly 50% were either born overseas or born in Australia with at least one parent born overseas. More than a quarter of Victorians spoke a language other than English at home, whilst almost 60% followed one of more than 130 different faiths.<sup>2</sup>

A language can be spoken in a number of countries and by people from different cultural backgrounds. For example, a Spanish-speaking patient's country of birth can be Spain or Chile; an Arabic-speaking patient can be from Iraq or Lebanon; Urdu is spoken in India and Pakistan. And practices in each culture may not be observed by all (or even most) of those from the same culture. For example, a patient from Turkey might agree to an internal gynaecological examination while another might refuse because she is unprepared for it and feels she will lose her dignity to show her unshaved pubic hair. Having said that, we also need to allow for changes in their views and thoughts that evolve with age, experiences and other factors after their migration to Australia. A Chinese or Vietnamese patient who has been in Australia for years may not have observed one month of confinement after childbirth, whereas her newly arrived friend from China or Vietnam may have. While we hold certain views about cultures in the following discussion, we have no intention to create any cultural stereotypes.

In some cultures, such as Vietnamese, Chinese, Greek and Turkish, medical professionals are highly respected and considered as acknowledged superior authorities and will be trusted entirely by some people, particularly women. Therefore, when they are told to make choices for their treatment, they get confused and are reluctant because they trust the professionals' opinion rather than their own. Some do not understand informed consent or are not aware they can refuse recommended treatment. Some even try to seek advice from interpreters.

These drag-on struggles about 'who should make the decision' between patients and professionals not only fail to effectively achieve positive outcomes, but also undermine the professionals' trust in the interpreters' competence in conveying their messages, and the patients' trust in the professionals who are seen as unwilling to tell them what to do.

Sometimes a patient's own misconception, inadequate education or lack of knowledge on human anatomy, may contribute to their hesitation. A few patients from Vietnamese and Turkish backgrounds who could not distinguish between a uterus and female genitals were reluctant to have a hysterectomy because they believed they could no longer have intercourse once their uteri were removed. Vietnamese patients sometimes would be reluctant to have a hormonal Mirena IUD. They implied a woman could not be a complete woman without a monthly period, unless they are menopausal.

From our experience, using drawings, pictures or three-dimensional models such as anatomical pelvic models to illustrate reproductive organs, for example, by health professionals, has proved highly beneficial to patients. A picture is worth a thousand words. Even when medical staff explain in simple English and

do not use jargon, visual demonstrations always help to improve and facilitate communication.

### Syntax of negative questions

English and some Asian language speakers process negative questions differently. The following example shows how this can lead to misunderstanding, poor interaction and even distrust among all parties involved, including interpreters.

A worrying husband who wished to confirm if his wife's infection would harm their baby rephrased his question, 'Doctor, doesn't it cause the baby any harm?' Being impatient with his repetition, the doctor just replied with one word, 'No!' For her, she meant no, it 'does not cause any harm'. But for the Chinese, Vietnamese or Japanese speakers, her answer indicated she disagreed to the negative question, which meant the infection 'does cause harm'. Before the interpreter could interpret, the husband (who spoke some English) felt the doctor contradicted herself and asked again for clarification, which in turn annoyed the doctor more. She raised her voice and said, 'No, it doesn't harm the baby.' Up to this point, all parties became agitated. The couple considered the doctor rude and inconsistent, and the doctor doubted the interpreter's competence in transferring the message.

In a similar scenario, after responding with a 'no' to the negative question, the doctor sensed their patient's confusion, further elaborated her answer and explained it again in a different way to help the patient understand. We also found if health professionals can closely observe facial expression and body language by maintaining eye contact with patients, it is more likely to achieve a satisfactory communication outcome.

### Asking sensitive questions

Women from some cultures are shy, introverted and submissive and tend to refrain from discussing sexual matters. For example, some older women who lost their husbands a very long time ago get offended when asked if they are still sexually active. In one scenario, the interpreter needed to step out of her role and clarify the misunderstanding before the professional could get answers from an angry African widow.

Some women would not speak of their sexual life when their children are present; some if accompanied by their partners would intentionally omit their current or past medical history.

### Family members' interference – acting as interpreters

The presence of family members is good to give patients support and supply extra information especially for elderly patients, but they should not replace interpreters. While patients from some cultures may prefer family members to be their interpreters, failure to use impartial and qualified professional interpreters can give rise to conflicts of interest and intentional misinterpretation.

A patient only found out she was not the cause of their infertility (but her husband was) when his female relative, who had always interpreted for her before, was unavailable and the hospital interpreter service was used. The interpreter recalled how the elated woman glowed with self-confidence when she knew

the truth. In some cultures, a divorce or polygamy is warranted if the wife is found infertile.

### Family members' interference – dominant partners

It is not uncommon for partners to interfere in patients' health affairs, when they speak little English and come from a culture where women's rights are not respected. Provision of a professional interpreting service empowers those women to speak freely.

One observation made by an interpreter is noteworthy: when patients come without their partners, they are more likely to ask many questions; when partners attend, they can take over the conversation with the health professionals who are satisfied to chat with the partners 'all in English'. In such a situation, to ensure the patient 'remains linguistically present',<sup>3</sup> the interpreter would offer whispered simultaneous interpreting for her. With all participants talking simultaneously (with the exception of the patient, the supposed focus), the communication is far from satisfactory.

One of the requests commonly made by family members is not to interpret 'bad news' to the patients or to avoid the word 'cancer' in the interpreted message. While we understand their motive might be love, interpreters must adhere to our responsibility, which is 'to ensure that the full intent of the communication is conveyed', and 'do not soften, strengthen or alter the messages....'<sup>3</sup>

Similarly, interpreters must also try their best to be accurate, 'faithful at all times to the meaning of ... messages'<sup>3</sup> and 'keep the participants informed of any side comments made by any of the parties...'<sup>3</sup> All parties are advised to refrain from uttering anything that they do not intend to be conveyed in an interpreting session.

### Role boundaries and perceptions

Some patients in small tight-knit communities would refuse interpreters from their communities because they do not trust them to abide by confidentiality in the course of their work.

However, on the other end of the spectrum, some patients perceive interpreters as their 'close allies' because they speak the same language and may come from the same cultures. They would consult us in their treatment; expect us to remember their medical history and conversations from previous consultations. Interpreters would try to make patients understand that we must 'maintain professional detachment, impartiality, objectivity and confidentiality'.<sup>3</sup> In fact, sitting and engaging in conversation with patients in the waiting area is not appropriate because it runs the risk of getting their medical information, which the patient expects the interpreter will later tell the health professional.

However, in-house interpreters working in an institutional setting are wearing two hats, playing the roles as staff members and independent interpreters. In carrying out our professional duties, it is also important to develop good rapport with patients, provide information on the services available and help clear up misunderstandings when appropriate. According to our code of ethics, interpreters are allowed to play a role in addition to interpreting as long as 'they clearly indicate when they are acting as interpreters and do not switch roles without notice'.<sup>3</sup>

As NAATI accredited interpreters whose credentials need to be recertified regularly like other professions, we perceive ourselves as professionals, not 'helpers'.

Sometimes we are present 'on standby' for patients' 'in case' incomprehension occurs, upon the patients' requests even though they communicate well in English. Our hands are not bound, but we feel our tongues (both our native and foreign ones) are 'tied'! Comments made by some professionals such as 'your job was easy because you didn't have to do anything' are even more discouraging. The interpreter does not sit idly, but is listening to every utterance attentively for the entire time to prepare for 'rescues' when necessary. However, by and large, interpreters are respected and their work is appreciated in Australia. 'Learning a language challenges you to see the world from a different and sometimes uncomfortable perspective – it broadens the mind more surely

than travel, and at the same time promotes cross-cultural empathy and understanding.'<sup>4</sup> Author and literary translator Linda Jaivin considers access to translation as a 'sensible corrective' for those who lack opportunities to learn another language.<sup>4</sup> In this sense, interpreters, verbal translators, are also providing this important access.

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# Strategies for working well with a Deaf person



**Rebekah Rose-Mundy**  
Member of the Australian Deaf Community,  
NAATI accredited Deaf Interpreter and member  
of the Australian Sign Language Interpreters  
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*I'm making my way to the hospital for my appointment and I'm feeling worried they won't have an interpreter because for the last few appointments there wasn't one and it was terrifying and frustrating. And then I think, if there is an interpreter, is it someone who can understand me, or what if it's my friend or a male interpreter? I wish this were something I knew before I arrived. And then I worry, if the interpreter doesn't arrive, they'll tell me my surgery has to be delayed because there isn't an interpreter, I am going to be so devastated and frustrated; I will have to rearrange my childcare, reschedule my support workers (what's that going to cost me!?) and my time off work and transport and not to mention, continue to live with this pain for who knows how long! And then I start thinking about whether the clinic is running on time and how long they've booked the interpreter for, what if the interpreter has to leave before I even see my doctor! When we're in the appointment, what if I don't understand what the doctor is saying, using all that fancy medical jargon.*

This is a common experience for many Auslan (Australian Sign Language) users in Australia. Even before a Deaf person has arrived at your clinic, they have had to consider so much above and beyond what a hearing person thinks about. Thankfully, there are range of strategies and actions professionals can take when they have an appointment with a Deaf client or family member.

Before we talk about strategies, it's important to clarify some terminology. The term Deaf (with a D) is commonly used by, and to refer to, people who identify with Deaf culture and use Auslan as their primary language. Being Deaf is a positive way of being. The term 'hard of hearing' is typically used to refer to people who identify as hard of hearing and align more with hearing culture. The term 'deafness' refers to the physiological experiences of having no, or reduced, hearing. Both Deaf and hard of hearing

people may have hearing aids or cochlear implants or no hearing devices at all, some may prefer to talk for themselves in English and some may have written English comprehension. However, it is particularly important to understand that each individual with deafness have varying ways of defining and expressing themselves and clinicians must respect each individual's choice.

## Strategies to work well with the Deaf person

Auslan is a visual language. It is a full and complex language separate to English and is specific to Australia. As it is a visual language, where possible, have diagrams, pictures, videos with captions and models handy. These extra tools, being very visual, can enhance communication and improve the Deaf person's understanding about their own health and their capacity to participate in their own health decisions. Being in a hearing-centred world, it's common for some Deaf people to have missed out on incidental learning opportunities, so allowing for extra time in the appointment to provide some additional education is important. As well, respectfully checking for understanding.

Building a rapport with your Deaf patient as well as your interpreter will also enhance communication. For some Deaf people, having an interpreter and a professional they have not met before, building that trust and rapport is particularly important. Prior experiences of arriving at their health appointments only to be told the interpreter isn't available and it has to be delayed (or being denied access to an interpreter) means that some Deaf people distrust the health system and health professionals. Furthermore, for health appointments that are particularly personal, some Deaf people are uncomfortable having an interpreter they just met in the room with them. It can be helpful at the start of the appointment to remind all parties that the professional interpreter is required to keep all things confidential. Learning how to greet people in Auslan can also be an effective way to show respect and build rapport.

Having consistent interpreters, especially in personal appointments like gynaecology, can help to build that rapport and trust. It's worth asking the Deaf person for their preferred interpreters and adding that to the interpreter booking form as well as any patient records. Additionally, at the end of the appointment, ask the Deaf person if they're happy to continue using the same interpreter. To avoid awkwardness with the interpreter currently there, you could write it down in simple English with a tick box so that they can do it privately to let you know.

Staff turn-over and availability of interpreters can make it difficult to have consistency. So if it isn't possible, effective and detailed handover between staff is crucial. This will mean that the Deaf person does not have to re-explain about their history, language, culture, preferred communication strategies, preferred interpreters and so on.



Oftentimes professionals need to explain about medication schedules and instructions for pre-surgery. This is important information but can be difficult to comprehend. It can be helpful to prepare a clear diagram and/or table (with pictures where possible) to make the instructions, dates and times clear for the Deaf person and interpreter; and give it to the Deaf person to take home and refer to. Similarly, consider a range of communication options (letters and emails in simple English, SMS or the National Relay Service) when communicating with patients about their appointments. If future appointments are needed, it's easier to organise them while the interpreter is there.

### Strategies to work with interpreters

It's also important for professionals to know how to work effectively with interpreters. If there is time before an appointment, and it is appropriate, providing the interpreter with any context or background information can help to ensure an effective interpretation.

When the interpreter is working, don't 'gawk' at them. It's natural to be fascinated by the process but this can erode the Deaf person's trust in you as well as the interpreter and make the most important person feel invisible. Always direct your attention to the Deaf person. Talk directly to them, 'how are you today?' rather than 'can you ask them how they are?' Equally, if you have any questions about Auslan or Deaf culture, direct them to the Deaf person.

If any physical examinations are necessary, allow the interpreter and Deaf person time to discuss how they would like to set up the room to ensure the Deaf person is comfortable.

Usually, there is quite a bit of medical jargon (medications, organs, conditions); be prepared the interpreter may ask you to explain what they mean. Try to use simple English, models, drawings and diagrams wherever possible.

There may also be appointments where there are two interpreters, a hearing Auslan->English interpreter and a Deaf interpreter usually working from Auslan into non-conventional Auslan. Deaf interpreters are NAATI certified and they work with many clients, but are particularly skilled to interpret for Deaf people

who are immigrants to Australia and aren't fluent in Auslan or have not developed a full language. When working with the two interpreters, continue to direct your attention to the patient and family and allow more time for the appointment.

### Preparing for an Auslan-interpreted appointment

If you're feeling unsure about anything ahead of your appointment with a Deaf person and you want to learn more about Auslan or Deaf culture or Auslan-friendly resources, there is plenty of information and resources available. The Australian Sign Language Interpreters Association (ASLIA) has video resources about how to work with interpreters. You can also find the Interpreter's Code of Ethics on their website. Any of the Deaf societies (such as Deaf Services, Deaf Can Do, Expression Australia, Access Plus) websites have information about where to learn Auslan or access Deaf Awareness Training. The Queensland Health, Statewide Deafness and Mental Health Services also has plenty of resources including 'Guidelines for working with people who are deaf or hard of hearing'.

Your efforts to ensure effective communication and culturally respectful behaviour are vital for the health and well-being of Deaf patients and their family.

*I'm making my way to the hospital for my follow-up appointment. I feel confident I have the right time and date from the letter they sent and I have followed all the pre-op instructions that were given in my visual instructions they prepared. I'm feeling confident the staff know why having an interpreter is important and will do their best to ensure an interpreter has been booked. I know they are aware of my preferred interpreters and who was the interpreter from my last appointment, so I feel confident the interpreter will be able to understand me. It's still possible the interpreter may not arrive and my surgery might have to be delayed, that's still a major concern. But I also know that if the clinic is running behind, the staff will make sure I am able to see the doctor before the interpreter needs to go. I'm also confident my doctor understands me and my culture, they treat me as someone who is capable of being involved in my own health and making decisions and ensure they give me information in a format that is easy for me to understand.*



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# Lucy's legacy: why Sims' speculum needs a different name

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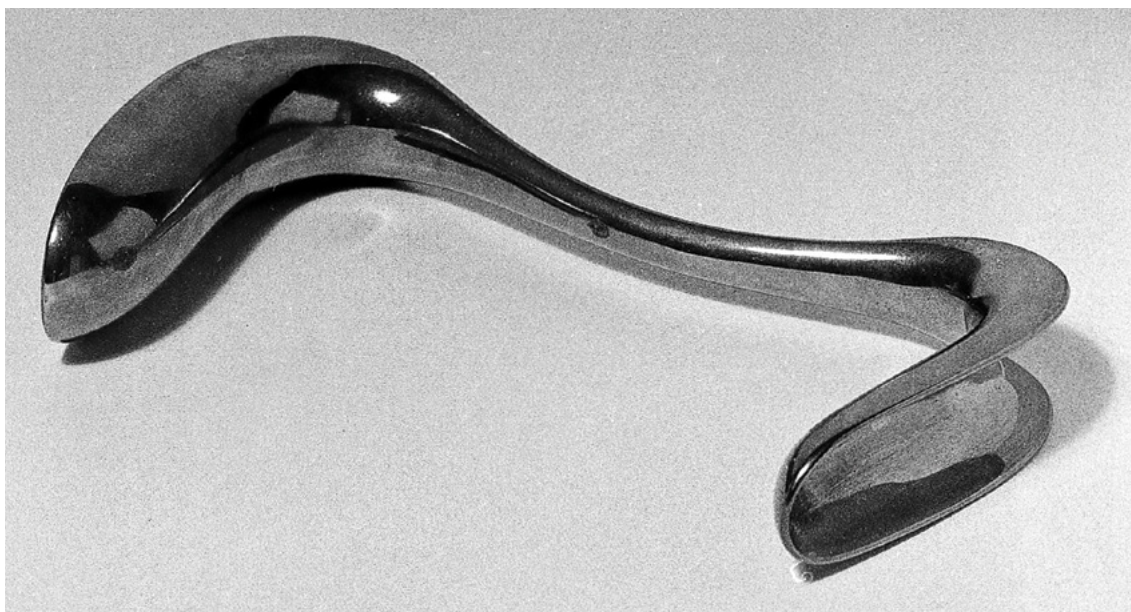
In this article, we provide a brief insight into the history of Sims' speculum, its namesake and why we believe it is time to rename it. We outline the main stakeholders who would be involved in the name-changing process, provide the rationale for renaming it Lucy's speculum, and outline our strategy to implement this change in the Australian medical community. We aim to not only change the name of Sims' speculum, but to start a conversation about the history of racism and misogyny in medicine.

The Sims' vaginal speculum owes its name to Dr J Marion Sims, the man upon whom the title 'father of modern gynaecology' was once bestowed.<sup>1</sup> For over a century, he comfortably maintained this title and was described as a heroic figure by doctors and medical textbooks alike. More recently, however, Sims' behaviour has been re-examined and knowledge of his various malpractices have come to light. Between the years of 1845 and 1849, Sims performed a series of experiments on enslaved African American women in order to perfect the surgical management of vesicovaginal fistula. Until 1849, Sims' operations all failed<sup>2</sup> and were carried out without anaesthesia, which first came into use in 1846.<sup>3</sup> Moreover, it remains unclear as to whether the patients consented to these procedures.<sup>4</sup> One slave, Anarcha, had 30 experiments performed on her after Sims failed to operate successfully time after time.<sup>1</sup> Sims' experiments caused obvious harm to his patients, including a slave named Lucy. After one unsuccessful procedure, Sims recorded that –

'Lucy's agony was extreme. She was much prostrated, and I thought that she was going to die. ... After she had recovered entirely from the effects of this unfortunate experiment, I put her on a table, to examine.'<sup>1</sup>

Although Sims' actions may have been in keeping with the societal and medical norms of his era, today they can only be viewed as abhorrent.

Interestingly, after perfecting his fistula repair technique, Sims performed the operation on numerous white women, always using anaesthesia during these procedures.<sup>4</sup> Additionally, Sims' intentions for perfecting the fistula repair procedure were at best, murky, and at worst, callous and narcissistic. Sims once stated that he 'hated... investigating the organs of the female pelvis' and 'felt no particular interest in [his] profession at the beginning... apart from making a living'.<sup>2</sup> From these statements, it is clear that his obsession with gynaecology arose once he recognised that he could earn a fortune by specialising in the field. Hence, he exploited the power imbalance that existed between African American slaves and white men in the 19th century. By using Sims' name to refer to the U-shaped speculum and the left lateral position for perineal and per-rectal examinations, we are condoning the unethical, sexist and racist actions of a man who used vulnerable African American women as a means to advance his status and career. More broadly, we are encouraging the exploitation of vulnerable communities in order



Marion Sims duck-bill obstetric speculum. Wellcome Collection. Attribution 4.0 International (CC BY 4.0).

to achieve personal and professional gain. It is our responsibility to make amends – we have already waited far too long to do so.

We propose that the Australian medical community follows in the footsteps of a growing American movement to acknowledge the brutality of Sims' actions. The University of Alabama has removed a painting depicting Sims as one of the 'Medical Giants of Alabama',<sup>5</sup> and the mayoral commission of New York City catalysed the relocation of Sims' statue from Central Park.<sup>5,6</sup> We suggest that the Sims speculum should be renamed after one of the slaves who endured the agony of Sims' inhumane experiments: Lucy.

This alternative name, Lucy's speculum, has already been adopted by several doctors, medical institutions and universities around the globe. Dr Kameelah Phillips, an O&G in New York, has spearheaded this international movement, and describes the desire to rename it to Lucy's speculum 'in honor of the named and unnamed black bodies that have contributed to our progression of science and medicine.' Dr Phillips has also thanked 'the thousands of doctors who have committed to Lucy's memory by using her name in [their] operating rooms and – in doing so – share her story.'

We are confident that this change can be implemented successfully in Australia, given its rapid uptake in other parts of the world, mirroring the strategies used to implement the name changes associated with conditions such as granulomatosis with polyangiitis<sup>7,8</sup> and reactive arthritis<sup>9</sup> in recent times.

There are many stakeholders who must be involved in the process of reclaiming the name of Sims' speculum. Doctors, who use the devices, as well as nurses and other theatre staff would have to start referring to the device as Lucy's speculum. Time and energy would need to be taken to re-educate all staff about the name change and reasons behind it. As part of this effort, several re-labelling changes would also need to occur. Hospitals would have to

relabel the devices, so as not to cause confusion. Furthermore, manufacturers would have to rebrand and re-advertise the U-shaped speculum.

Aside from renaming the physical instrument, amendments would need to be made to educational materials. For example, hospitals and guideline-developing organisations may have to rename the device in management guidelines and protocols. Furthermore, the change of terminology would be particularly important whilst teaching medical and other healthcare students. As such, universities will hold a major stake in this change. From lecture slides to recommended textbooks and other resources, it would take a concerted effort for university lecturers, tutors and administrators to make the necessary changes.

However, patients must also be at the centre of this movement. Patient advocate groups for conditions that commonly require the use of Sims speculum should be consulted throughout the process. These would include patient advocate groups for conditions such as endometriosis and infertility. In particular, the voices of women of colour, who were historically most affected by men like Sims, should be amplified in this campaign. The doctor-patient relationship centres around trust, and this is more relevant than ever during gynaecological procedures. As such, it is essential that the language we use creates an environment in which all people feel comfortable and accepted.

We recognise that changing the name of Sims speculum to Lucy's speculum, is not a simple task. The breadth of stakeholders invested in the Sims speculum render a one-dimensional campaign ineffective. For this reason, the advocacy campaign we envision is multifaceted and aims to create both systemic and cultural change.

In order to change current practice, we would target systemic factors, primarily labelling used by speculum manufacturers, hospitals, outpatient facilities as well as general practices. A digital package, explaining the name change and providing a template for stickers

to change the product's name, could be provided to all these facilities. This would be a way to simplify and centralise the process. We would also focus on informing future practitioners through educating students and targeting educational facilities. A package could be distributed to universities, with a focus on educational material about the history of Sims and the development of the speculum.

Parallel to this, a dialectical approach would target practitioners and encourage conversations between staff to spread the word about the new name. Informal discussions between colleagues in theatre or tea rooms could be reinforced by physical markers of commitment to the change such as posters advertising the name change for communal staff areas. Furthermore, individuals could wear stickers on their name badges and lanyards. Funding to support this initiative, such as from medical societies, could allow these to be widely distributed. Simultaneously, a virtual campaign would continue the conversation outside of the workplace. We would run a broad social media campaign, primarily on Twitter and Facebook, targeting individual healthcare professionals and using the hashtag #lucyslegacy. We would also engage patient advocacy groups online, and utilise their large forums, to provide a consumer voice to the campaign.

Increasingly, the importance of language in medicine is being recognised. By continuing to award Sims with the name of the speculum, we are condoning the history of violence and abuse and implicitly lauding Sims for his contributions. This campaign represents an opportunity to solidify modern

Australian O&Gs', as well as the whole medical communities', commitment to patient-centred, non-discriminatory healthcare, leaving Sims and his practices in the 19th century where they belong.

The authors of this article are a group of medical students from around Australia who are all members of the Australian Medical Students Association (AMSA) Sexual and Reproductive Health committee in 2021.

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# Is it time to lose our virginity?



**Dr Sarah M van der Wal**  
**MBBS Hons, FRANZCOG**  
**Director of Obstetrics and Gynaecology**  
**Echuca Regional Health**

What is virginity? What is a virgin? Why do we place such high regard for the status of 'virginity?' In the original Hebrew, an *Almah* was simply a young woman of childbearing age – the literal virgin status of Mary. As time evolved, the Latin *virgo* came to mean a sexually inexperienced young woman. Now we hold fast to a concept that we can no longer define. Moreover, it is a concept that has significant influence over most young people and permeates our culture in all its forms. Countless film scenes, from the desecration of baked goods to the soft focus of a dream, countless books and periodicals, and countless sex-ed tapes revolve around the concept – or more specifically, the loss of it.

How does one lose one's virginity? A strict dictionary definition would be to 'have sexual intercourse.' The main problem with this, as a definition, is that one then needs to define sexual intercourse. In the heteronormative world view, this consists of placing a penis inside a vagina. This alone leads to further questions regarding orgasm, ejaculation and the requirement of either for it to be considered 'sex', but also leads to further, more confusing questions. If one has not had vaginal intercourse with a penis, but has had anal intercourse, then is one still a virgin? There's certainly more than one tongue-in-cheek musical number suggesting so. Most people, however, would argue: no. What then do young people who are not heterosexually inclined define as their sexual debut? If every person has their own definition of what a sexual encounter is, then 'sex' as a concept is fluid and undefinable, meaning the word 'virgin' is also undefinable.

Why is this important? Because regardless of slippery definitions, virginity as a concept, and as a word in our language, holds fast. Virginity is a social construct, and one that arguably has evolved to be about the commodification of women. It goes hand in hand with asking a prospective partners' parent for their hand in marriage and the age-old tradition of walking down the aisle and giving someone away.

The language around virginity holds tightly to the same concept, one of 'give', 'take', 'guard'. Common parlance says that you 'lose' your virginity, rather than share a special first moment with someone. It also revolves around the concept of one partner taking something from the other, in a moment of conquest. In the heteronormative parlance, this is usually a male taking something from a female, in a victory of sorts. The woman has then lost or surrendered a valuable good. It is undeniable that this ties in with the inverse relationship of sexual activity to gender: where a male is praised for losing his virginity and being sexually active, where a woman is shamed for doing and enjoying the same.

'Losing' one's virginity at the wrong time (usually too early), to the wrong person, or in the wrong kind of relationship are still active concepts.

Equally active is the myth that virginity can be defined as a biological entity based on hymenal integrity. Hymens can be disrupted with no sexual activity, and sexual activity does not necessarily change the anatomical alignment of the hymen; however, 'virginity checks' and medical concern regarding the hymen still abounds.

The language of virginity pierces deep into medical language and the way we conduct our business. For those of us who take a sexual history, the question 'are you sexually active' is one that has a binary answer – yes or no – but defines absolutely nothing about what a patient is actually doing with themselves (or someone else, as the case may be). More relevant questions revolve around specific risks – STIs, pregnancy, safety – but we are loathe to answer those. We too, place a line in the sand with the medical term 'coitarche', which is basically interchangeable with 'virginity' and impossible to define without excluding a huge swathe of sexual experience, some of which is extremely relevant when taking a sexual history for medical purposes.

There is a general taboo for doing pelvic and gynaecological exams on people who have not yet had 'intercourse', as though disrupting a hymen will steal something from a future sexual experience. I stand firmly by the principle of not performing deeply intimate exams unless absolutely necessary, but should 'virginity' be a part of that decision making?

Virginity ties in strongly to the concept of abstinence. The notion of some kind of moral and physical purity from the avoidance of sexual activity but, more specifically, sexual intercourse (defined here usually as the heteronormative penile penetration of a vagina). The ramifications of purity culture across the religions and cultures of the world cannot be understated, and the ripple effect into women's health has been enormous. Availability of contraception, non-abstinence-based sexual education and frank discussion of risk have all been affected by the concept of purity and virginity.

People who are not engaging in penile-vaginal sex are still at risk for a range of health-related conditions that may be tested for, avoided, or educated about. People who are ostensibly 'virgins' cannot be excluded from a range of medical education and care, simply on the basis of an undefinable line in the sand.

By continuing to adhere to, and believe in, the concept of virginity, we exclude a huge number of people from the discussion, minimising their

experiences. It invalidates intimate experience in many relationships, it's heteronormative, and arguably, sexist.

Language around virginity upholds the language of sexism, of commodification of non-male bodies, and of patriarchal, heteronormative ownership in a way that is no longer valid or accepted. Moreover, in the medical sphere, it lends itself to a ballooning possible set of uninformed notions that may potentially increase harm.

It is possible to remove the concept of virginity, and its importance, while still respecting cultural and religious beliefs around the choices people make with their own body. Choice around sexual activity and decisions must be fully self-controlled and consensual, and it's entirely possible to hold respectful decisions and, at the same time, remove a harmful concept from the world in general, and from our language.

So, I put to you: isn't it time we all lose our virginity?



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# Speaking with young women in pregnancy



**Meg Wearden**  
**BMid, BSc, MSocSc**  
**Registered Midwife**  
**Logan Hospital**  
**Midwifery Group Practice**



**Alana Classen**  
**BMid**  
**Registered Midwife**  
**Logan Hospital**  
**Midwifery Group Practice**

*Rad, cool, FOMO, YOLO, Flex, No Cap, On Fleek...*  
 Aside from an unexpected and well-placed swear word, inserting 'on trend' lingo as a means of building meaningful rapport with adolescents is cringe worthy and rarely, if ever, effective.

Relatively new to the industry, we (Alana and Meg) have spent the majority of our midwifery careers working in the Young Women's Midwifery Group Practice (MGP) at Logan Hospital, just south of Brisbane, Queensland. The Logan demographic is extremely diverse and complex, which is reflected in the women who come into our care. The birth rate for women between 15–24 years was 50% greater in the Logan LGA compared to the Queensland average, with the number of births to teenage women in particular, significantly higher.<sup>1</sup> It is known that

teenagers in Australia who become pregnant are more likely to have poor mental health outcomes, low levels of health literacy, have experienced unstable housing and to be socioeconomically disadvantaged compared to teenagers who do not become pregnant.<sup>2</sup> Effective communication is fundamental in our practice in order to build rapport and provide quality woman-centered care.

## Adaptive modes of communication

It is important to have open communication with the women in order to provide individualised care; however, barriers exist for health professionals when communicating with young women. We have found being considerate and utilising the mediums available to us helpful in creating a safe space to communicate with the young women. In MGP, the women are given our work phone number and are encouraged to call us with any questions or concerns throughout their pregnancy, labour/birth and postpartum period. In our experience, the women are initially reluctant to answer a call from an unknown number, let alone talk on the phone with a health professional about their newly discovered pregnancy. The constraints enforced by mainstream care have created barriers that young mums describe as being 'tense', 'too rigid', 'not friendly' and 'impatient'.<sup>3</sup> In MGP, we have adapted to this cohort of young women by initiating contact and communicating via text message. The women find this method of communication more comfortable as they are able to do their own research, talk things through with people they trust, respond with questions and agree to engage without the pressuring feeling of a phone call. Similarly, young mums will often feel more comfortable asking awkward questions via texts, such as 'will an orgasm hurt my baby?' Of course, it is reiterated from the outset that any concerns regarding the immediate wellbeing of mum or baby needs to be communicated via a phone call.

## Relatable approach to education

Often the young women we work with have had very limited experience and exposure to birth. We have noticed women become more engaged, willing to ask questions and are able to comprehend information when it's delivered in a way that is relevant to them. To do this, Alana will often cast her mind back to when she was a teenager and what she knew about pregnancy, birth and female anatomy – which she admits was not much! Alana will often relate her education to something familiar to the young woman. For example, when explaining the anatomy of the female reproductive system and function of the cervix, Alana will discuss inserting a tampon to explain the cervix and location of baby. Women are often surprised to learn that all the dilation takes place inside their body and changes to the vagina cannot be seen until the late stages of the birth process, demonstrating the need for internal vaginal exams.

Furthermore, Hollywood's cinematic portrayal of birth can create unrealistic expectations. We enjoy having conversations with our new mums about how unlikely it is that they will be walking through Kmart, when all of a sudden, their waters break everywhere and a baby comes flying out! This creates a lighthearted platform to explore and segue into realistic conversation about birth and what to expect.

Referring back to her teenage years is not quite so easy for Meg. Instead, she makes use of the 'What to Expect' brochure that all of our young women are given. Meg slowly works through elements of the brochure at each appointment. This way, the women have access to the same information when they go home and can revisit and review if they don't remember or understand something that was discussed. Meg encourages her clients to interact with the document: write questions, highlight areas of intrigue for further discussion and identify areas of concern – all which contribute to forming birth preferences. Similarly, sending educational pictures or short videos via texts creates a reference point that they can reference back to at a time that works best for them and when learning that information feels relevant.

### Communication techniques

It seems obvious, but two of the most successful communication techniques we utilise are repetition and recall. Arguably, the most important information we share with our women is ensuring they know when to contact their midwife and signs of an unwell baby. Asking women to explain 'what might you be experiencing if you thought you were in labour?' And how would that be different to ligament pain?' or 'what might your baby be doing or not doing to show they aren't well?' is helpful in highlighting gaps in knowledge and level of comprehension. It creates opportunity for clarification and often the women are more engaged in the ensuing conversation as they become more attuned to their own knowledge deficit.

### Gentle conversations

For many young mums, the responsibility of growing a human can be overwhelming and isolating, particularly when it comes to discussing 'normal' fetal movements as per the Safer Baby Bundle.

Generally, the women we care for have not had an opportunity to hold such a high level of responsibility or build trust in their body and their decision making. If they can't ask for anyone else's opinion or advice, they may find themselves solely responsible for an answer that, if 'incorrect', can have incomprehensible consequences. Asking a young mum 'is your baby moving normally?' is very direct and can immediately instill panic. We try to soften our questioning to ask 'how is baby moving?' and prior to this discussion we might comment on baby's movements while attending to an abdominal palp, or making light of baby's movements keeping mum awake all night. This is in no way to coerce a particular answer, but rather to create a positive frame of reference to help temper what can be a very anxiety-inducing questions.

### Encouraging autonomy

Finally, we strongly recognise that our role in continuity of care is creating opportunities for our women to build confidence in themselves and the ability to advocate for their needs and, as new mums, to advocate for the needs of their family. Our clients are often still in school or have only recently finished and are familiar with the power dynamics associated with people in positions of authority. Consequently, they often minimise their own voice, trusting blindly in their care providers and hold a perception that asking questions of authority can be negatively received. In order to facilitate women-centered care, it is important that our women understand they can ask questions, decline care options and that this will be heard and respected. Our clients are acutely aware that they are allowed to say 'no' to any level of intervention and are celebrated when they question a particular pathway of care.

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# English, the language that lurks in dark alleyways



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*'We don't just borrow words; on occasion, English has pursued other languages down alleyways to beat them unconscious and rifle their pockets for new vocabulary.'* [James D. Nicoll 1990]<sup>1</sup>

The English language has filched an astonishing three quarters of its vocabulary from other languages, and a good example is the sizable French- and Latin-based loot that has ended up in the lexical coffers of Medical English — very little Medical English is in fact English.

We have Anglo-Saxon first aid kits dating from the 9th century, but only a handful of the medical word-hoard of 'Old English' survives. *Lacnian*, meaning 'to heal', spawned a number of terms including the all-important *læce* 'leech' or 'medical practitioner'. But while leeches live on as 'blood-sucking worms', most of the old terms have bitten the dust (eg. *læcedom* 'a medicine'; *læcegetawu* 'medical instruments'; *læcecest* 'medical chest'; *læceseax* 'lancet'). Of the numerous words for 'disease' (eg. *cōpu*, *adl*, *untrumness*, *suht*, *unhælh*), only *seocnes* ('sickness') survives, more or less in tact. Words to describe the *adligende* ('patient') include *unstrang* ('unstrong'), *unmeaht* ('weak'), *lef* ('injured'), *untrymig* ('ill'), *unhæle* ('sick') and *besmitten* ('infected') — only *(be)smitten* remains to describe the lovesick heart.

One notable survivor, but from the later medieval English period, is *midwife* (from 1300). This is an interesting word because it nicely preserves relics of earlier meanings that have long departed — *wife* means here 'female' (not 'married female', as it does today), and *mid* means 'with, by' (this preposition has totally disappeared). So the *midwife* was 'the woman (*wife*) with (*mid*) the mother at childbirth'. The word was once commonly pronounced <midiff>, similar to the shortened pronunciation of *midwifery*; compare *housewife* > *hussif* / *hussy* (clearly the meanings of *housewife* and *hussy* have parted ways!) and also *goodwife* > *goodif* / *goody* ('mistress', as in 'Little Goody Two-Shoes', who gave us *goody two-shoes* to describe the do-gooder).

## The French conquest of English

*Midwife* is unusual because the medical terminology of 'Middle English' was completely overrun by French and Latin words. This marked the beginning of our passionate affair with a practice curiously called 'borrowing' (English of course has no intention of giving these words back)! It all started with the Battle of Hastings in 1066. Linguistically, this was a French coup — after William the Conqueror took the throne, the Normans controlled the state, the military, cultural and intellectual interests, and an estimated 10,000 French words flooded into these areas, sometimes as brand-new additions, sometimes ousting the Old English expressions, and sometimes existing side by side (but usually diverging in meaning and style).

Among the sciences, it was medicine that incorporated the largest number of these; even some of the Latin and Greek medical terms came into English via Anglo Norman.<sup>2</sup> Most of these words are still the core of modern Medical English, and the following are just some examples:

*medicine, surgery, surgeon, doctor, physician, patient, malady, pain, disease, apothecary, distemper, palsy, pleurisy, gout, jaundice, infection, plague, pestilence, pus, pustule, contagion, anatomy, remedy, ointment, hospital*

## English 'would play the bankrupt with books'

The pilfering continued during the Renaissance period (the start of 'Modern English') and during the centuries that followed. Every new discovery, every new invention, needed a name, and those that were created were overwhelmingly Latin and Greek in their derivation. Quite simply, people felt English wasn't up to the task of creating specialist terms such as those needed in medicine — indeed, in 1613 Francis Bacon described English as being among those modern languages that 'would play the bankrupt with books'.<sup>3</sup>

Scholarly vocabulary flooded in, and this changed the nature of English for all time. Giving objects and concepts a classical name gave them an exclusivity, and this bred a kind of intellectual snobbery. Even ordinary language was crammed full of classically inspired expressions to replace those native English ones deemed not up to scratch. Words such as *deruncinate* ('to prune'), *pistate* ('to bake') and *carbunculate* ('to burn') were 'inkhorn terms', the 16th century label for over-the-top literary coinages (cp. the contemporaneous expression 'to *smell of the inkhorn*' meaning 'to be pedantic').<sup>4</sup>

Some of these were also undoubtedly 'hothouse words', a label created by Arthur Kennedy in 1927 for the 'ponderously erudite' words coined by early dictionary makers, who then placed them into their word books.<sup>5</sup> Perhaps they felt that hothouse sprouts like *galericulate* ('covered as with a hat'), *gymnologize* ('to dispute while naked') and *nugipolyloquous* ('speaking much about trifles') could be useful, or perhaps they simply wanted to display their knowledge of Greek and Latin. Whatever the motivation, once placed in the protective

environment of the hothouse, many of these words survived by being picked up by later dictionaries (plagiarism being a common lexicographical practice). *Doctiloquent* ('speaking learnedly'); *defensative* ('a medicated ointment'); *dropacist* ('a depilatory'); *diaciminon* ('a preparation for "windines in the stomach") are just some of the medically useful D entries of Thomas Blount's *Glossographia; or, a dictionary interpreting the hard words* (1656). Like most, these never made it out of the hothouse.<sup>6</sup>

The quacks seemed to have the most fun with these grandiloquent words. My favourite example is the patter accompanying one quack's 'Friendly Pills'.<sup>7</sup> Also known as the 'Never Failing Heliogenes', these remarkable tablets worked on the 'Gelastick Muscles' in 'several seven different ways':

'Hypnotically, Hydrotically, Cathartically, Proppysinatally, Hydragoically, Pulmatically, and last Synecdochically, by corroborating the whole Oeconomia Animalis.'

Whether these quacks were well-intentioned or not, one thing they all excelled at was the art of publicity — and puffery.<sup>8</sup> And it's probably not surprising that this time coincides with the deterioration of the verb *to doctor*: 'to treat, as a doctor or physician; to administer medicine or medical treatment to' > 'to falsify, tamper with, adulterate'. According to the Oxford English Dictionary, the first appearance of this negative meaning in print was in 1777. I also find it telling that *apothecary* is among the 4,000 colloquialisms in Captain Grose's *Dictionary of the Vulgar Tongue* (1785); Grose defines *apothecary* as: 'to use hard [= obscure] words; from the assumed gravity and affectation of knowledge generally put on by the gentlemen of that profession, who are commonly as superficial in their learnings as they are pedantical in their language'.

I should add here that some 'hard words' from this time did in fact survive, and a number are now even part of everyday language (eg. *agile*, *crisis*, *exact*); they include basic medical terms (eg. *epilepsy*, *glottis*, *larynx*, *pancreas*, *pneumonia*, *skeleton*, *temperature*, *tendon*, *thermometer*, *tibia*, *virus*).

#### A black eye versus a circumorbital haematoma

The vocabulary of Modern English shows an interesting hierarchical patterning that is the fall-out of this linguistic larceny. I've always found a carpet analogy helpful here (but don't push it too far). Our native English vocabulary, the words of Germanic origin, provide the basic underlay; in other words, our everyday vocabulary (eg. *body*, *blood*, *finger*). Typically these words are shorter, more concrete and stylistically neutral; they include the obscenities (ie. the worst of 'four letter words') and the grammatical words (eg. *a*, *the*, *and*, *be*). In fact, 96 of the 100 most frequent words in written Modern English appeared in Old English.<sup>9</sup> The other four (*are*, *they*, *them*, *their*) are Old Norse, a close relative of English — so close in fact that it's difficult to assess the true extent of the Viking contribution to English. It's not clear, for example, whether *ill* was Old English or entered from Old Norse (does it even matter if the two were basically dialects?).

But to continue my floor covering analogy, this Germanic underlay or foundation supports a quality carpet on top — a kind lexical superstructure comprising vocabulary items of refinement and nuance that come to us from French. Dotted on top of this quality carpet are the classy scatter rugs.

These are the words with connotations of learning, science and abstraction, and they come to us from the classical languages, mainly Latin and Greek. These two have long been the deodorising languages for English (eg. *perspire* instead of *sweat*, *expectorate* instead of *spit*, *defecate* and *faeces* instead of *shit*, *anus* instead of *arsehole*, *genitals* or *genitalia* instead of *sex organs*).

The contrast in style is striking when the Romance and classical superstructure provides the adjectives for Germanic nouns: compare English nouns like *mouth*, *nose*, *tooth* with the Romance-inspired adjectives *oral*, *nasal*, *dental*. When English does offer an adjective, there's a world of stylistic difference — *oral*, *nasal*, *dental* versus *mouthy*, *nosey*, *toothy*.

#### Bring back flesh-strings and arse-ropes

So, should we expunge the linguistic aliens and restore the lost English vocabulary — *unleech* ('bad physician'), *flesh-strings* ('muscles'), *arse-ropes* ('intestines') perhaps? In fact, this very idea has cropped up throughout the recent history of English, with a number of people wanting to abolish altogether the French and classical dimension to the lexicon. They include influential writers like Charles Dickens and Gerald Manley Hopkins through to the modern-day conlangers (or constructed language users). Some have sought to revive lost native vocabulary like *inwit* instead of *conscience*. Some have gone as far as inventing words. Among the gems coined by Australia's own Percy Grainger is *cut-cure-craft* for *surgery*. It never took off, not surprisingly — neither did *gainst-stir* (for *reaction*) or *meat-shun-ment* (for *vegetarianism*).

So now to some sort of *conclusion*, or *endsay*. Were we to put Medical English into a winnowing mill and blow all the borrowings out, there wouldn't be much left — certainly little of lexical excitement. In fact, it's dismal to imagine an English without its exotics — *medicine* would return to *leechcraft*, *horticulture* to *wortcraft* and my own discipline of *linguistics* to *speechcraft* or *speechlore*. I can't imagine *dentists* wanting to be *tooth-drawers* again. The British humorist Paul Jennings once rendered the opening lines of Hamlet's famous soliloquy into pure English. It began: 'To be or not to be; that is the ask-thing'. Says it all really.

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# Respectful language and perinatal loss



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Each birth is a unique experience and is influenced by many variables. If it is true that not everything can be foreseen and planned, it is equally true that

every woman placed at the centre of her path and accompanied by a solid network of support and care can live any experience of childbirth in the best possible way, with respect and awareness.

Recently, communication has gained more and more importance in healthcare: how bad news is broken is essential for the wellbeing of patients and healthcare practitioners (HCPs). This topic assumes a pivotal role when a perinatal loss occurs: grieving parents have invested in a life project that they must necessarily redefine and modify, and negative interactions with HCPs are added to the trauma that they are experiencing. On the other hand, compassionate care positively affects traumatic symptoms, helping bereaved parents to cope with grief.<sup>1</sup> It is crucial for caregivers to work with grieving couples to reduce the impact of the event and to enhance post-traumatic recovery.<sup>2</sup>

Co-building an imaginary of possible, multifaceted and inclusive childbirth, allows HCPs to favour the application of the principles of respectful and compassionate care in any birth experience, however dramatic it is. It also allows to reduce the impact of the 'unspoken' around labour and birth, often still considered intimate, private and unspoken spaces, especially in case of loss.

Every life event, even the happiest, is characterised by shifting the psychophysical balance of people who live it, pushing them towards rebalancing and readaptation to a new situation. When the life event is negative or even destructive, as in the case of perinatal loss, its effects on the psychophysical wellbeing are enormous and very often for HCPs there is nothing else to do than use a respectful and non-judgmental communication channel.

Nowadays, respectful communication and language represent the core of patient-centred care, which is an essential part of care after stillbirth as recommended in all guidelines on stillbirth and neonatal death.<sup>7</sup>

However, many mothers still highlight HCPs' inadequate communication skills, perceiving practitioners as vague and avoidant when a stillbirth occurs.<sup>3,4</sup> Similarly, HCPs recognise their difficulties when facing this type of event<sup>5</sup> and they have pointed their attention to the key role of suitable communication skills.<sup>6</sup>

Literature offers some useful instruments to HCPs when breaking bad news in a respectful manner. For instance, the SPIKES protocol, born in the oncology field, is an easy-to-follow guideline that can be applied in perinatal care.<sup>8,9</sup> It guides the HCP before, during and after the communication of the diagnosis, focusing on respectful language and promoting 'shared decision making'.

Clinicians and researchers involved in stress response and stress-related outcomes know that to promote the best response to a stressful life event it is important to equip the person with certain tools which are part of the process of shared decision making. Among these tools stands out the availability of correct information related to that experience and its management, the possibility of receiving emotional and professional support from competent people, and the possibility of making the best possible decision for themselves, while maintaining their autonomy and self-determination. These tools allow the suffering person and their caregivers to work on the experience in a competent, safe and respectful way.

Stillbirth is a dramatic event that involves HCPs too. It is amongst the most difficult experiences for health professionals and the fact that 95% of them report negative psychological symptoms after such loss is proof of that.<sup>10,11</sup> Moreover, HCPs' emotional burden could impact care due to their attitudes during hospitalisation and follow-up, influencing parents' wellbeing and their approach toward the baby.<sup>12</sup> Helping HCPs to deal with their emotional status should be of primary importance to guarantee an adequate job environment, which in turn is essential for the best possible care.

As mentioned above, respectful language is a key point of patient-centred care, and it is essential to avoid further traumas to parents. Moreover, it is the only tool HCPs have at their disposal to meet the couple's need to be acknowledged as parents, and the baby's right to have his existence and their impact recognised outside of the parental dyad. Stillbirth undermines a person's identity and their social role, which has then to be reconstructed and redefined. This task goes through the acknowledgment of parenthood by the couple itself and by others; for example, referring to the parents using words such as 'mum' or 'dad' could be a simple yet extremely helpful step to support them during the first numbing hours and days after the loss.

There is a wide agreement that specific training is required to learn respectful communication, as general communication skills and HCPs' personal experiences are not necessarily enough to meet bereaved parents' needs. Moreover, empathy is a learned construct, so it is necessary to have solid theoretical and practical knowledge; participating in specific training might help to build the necessary skills.<sup>13</sup> This has been previously highlighted in literature: studies such as BLOSSoM<sup>2</sup> showed that only half of midwives usually say 'I'm sorry' to parents during the diagnosis of a stillbirth though parents recognise it as a widely appreciated approach.<sup>14</sup>

Finally, we strongly believe that it is necessary to increase not just HCPs' awareness on the use of respectful language but also that of researchers, for two main reasons: HCPs use scientific literature as the main source of their knowledge and, more importantly, research should meet the parents' needs such as respect and understanding, since nowadays women and families can easily access academic journals. Adopting woman-centred, respectful language when writing about pregnancy, childbirth, and puerperium, and considering the effect of those words on the people who will read them, may well help to elevate respectful care into usual care.<sup>7</sup>

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# Understanding the language of pelvic pain



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Imagine a medical consultation with no direct language communication between the physician and the patient. This is what happens when the patient is a young child, or an older person who is suffering cognitive impairment. Or when the healthcare professional and patient do not share a common language. These scenarios are not atypical, and there are work-arounds, in the form of a parent, a family member or friend, or an interpreter.

We propose that pelvic pain also represents a condition where a common language is lacking. Where language linking a woman's experience with known pathologies has not been adequately developed. Where factors including gender, cultural background, age, ethnicity, education and language competence all affect the description of pain and add to potential misunderstandings.<sup>1-4</sup>

From the point of view of the physician, around 50% of Australia's health professionals come from overseas. While many of these professionals do indeed come from English-speaking countries, or at least underwent English-speaking medical training, intercultural communication is an increasingly complicated aspect of medical care in Australia.<sup>4,6</sup> For example, in many parts of Asia, patients are traditionally taught that it is inappropriate to ask unprompted questions of a doctor, and doctors do not expect such questions. Many follow these practices in medical consultations in Australia.

These factors are even more complex when we consider pain in women. Strong et al<sup>5</sup> asked male and female students to write about their experience of severe pain. Women used a more elaborate repertoire of pain expressions than a comparable cohort of males. They used more individual pain words from the McGill Pain Questionnaire,<sup>6</sup> more evocative language, and more elaborate descriptions involving figures of speech like similes:

*The swelling felt like the skin would burst and the burning in the bone made me feel like my head would explode.*

Males were more likely to use concrete expressions and, on occasion, vulgar language.

Accurate epidemiological data on the prevalence of pelvic pain remains incomplete. However, Parker et al<sup>7</sup> have shown that 20% of a cohort of school-age female students in Canberra suffered significant dysmenorrhoea, and variable degrees of associated pelvic pain conditions. Delgado<sup>8</sup> puts the prevalence of pelvic pain at 15%–20%; and Lamvu et al<sup>9</sup> estimate that chronic pelvic pain affects 26% of the world's female population. For women in pain, the question of 'frank and full' communication is even more complicated, as the pelvis includes organs and functions related to two of the strongest taboos in language and culture: reproduction and the elimination of bodily wastes.<sup>10</sup> Despite this, women may put substantial effort into describing what their pain feels like, in an attempt to convey useful information to their health practitioner.

Considerations like these have led us to launch a program of research into a more deep-reaching understanding of pelvic pain talk, and how this may facilitate improved communication between women with pelvic pain and health practitioners. History-taking in medicine involves pattern recognition. Descriptions of pain and their correlation with underlying pathologies have been developed over

centuries. For example, a *gnawing* pain in the right hypochondrium that radiates to the right shoulder, associated with nausea or vomiting, suggests gall bladder disease. A *constant* pain in the upper abdomen that radiates to the back, associated with diarrhoea and weight loss, may indicate pancreatitis. The single-word language of pain in these organs – *gnawing*, *constant* – has been well tested over time. They are not unique descriptors, but they do point a diagnosis strongly in specific directions for further exploration.

But what of pelvic pain, and the many varied descriptions women use, especially where laparoscopy and scans are normal, and no diagnosis has been made? We suggest that the language of pelvic pain has not yet benefited from this kind of evidence. A number of the relevant female pain symptoms were categorised under the psychiatric diagnosis 'Hysteria' until DSM 3,<sup>11</sup> and were only removed in 1987. Outside the framework of DSM 3, chronic female pelvic pain has been left without structured diagnostic links. It is disconcerting for both patients and physicians to be unable to associate pain with specific pathologies, especially when it is so difficult to characterise the many kinds of female chronic pelvic pain. There is a risk that delayed or uncertain diagnoses may lead to indecisive or inconclusive treatment.

Is there a distinct language for female pelvic pain, parallel to the ways in which language can help to point to gall bladder pain or pancreatitis? Can we match pain descriptors with an organ system, or an underlying pain mechanism? Can we determine the common pain descriptors and how they are used? And more broadly, can we improve communication between a woman and her health practitioner?

Our group has recently undertaken an online survey into women's pelvic pain. We asked women to describe their pain, fully and frankly, using as many words as they wished. The response from women in pain was overwhelming. We are engaged in analysing this rich data source using language analysis software to develop a Language of Pelvic Pain.

We now present some select initial findings from this ongoing research. These findings specifically consider dysmenorrhoea-related pelvic pain.

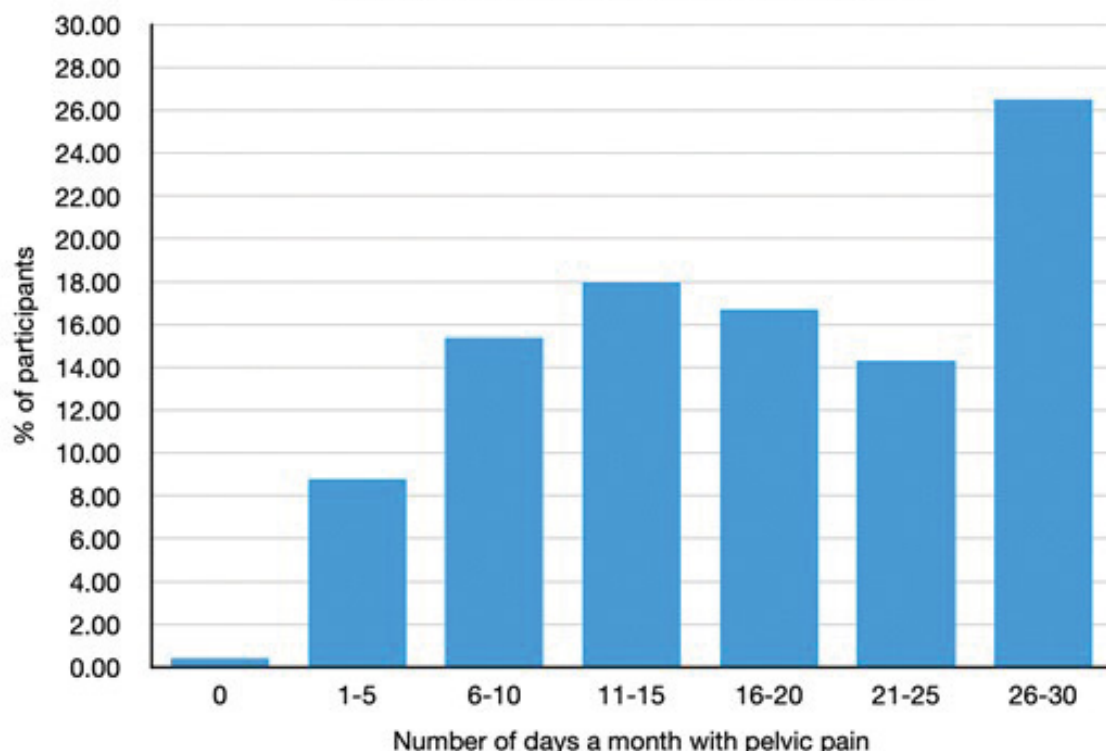
#### A data-based diagnostic approach to language and female pelvic pain

A convenient place to start is single-word pain descriptors. This approach to the identification and characterisation of pain has an established place in pain studies since the introduction of the McGill Pain Questionnaire,<sup>6</sup> which used 78 adjectives and a scoring algorithm to assess especially the intensity and subjective effect of pain. Our approach focuses also on the relation of words to triangulation and pattern-recognition in medical diagnosis.

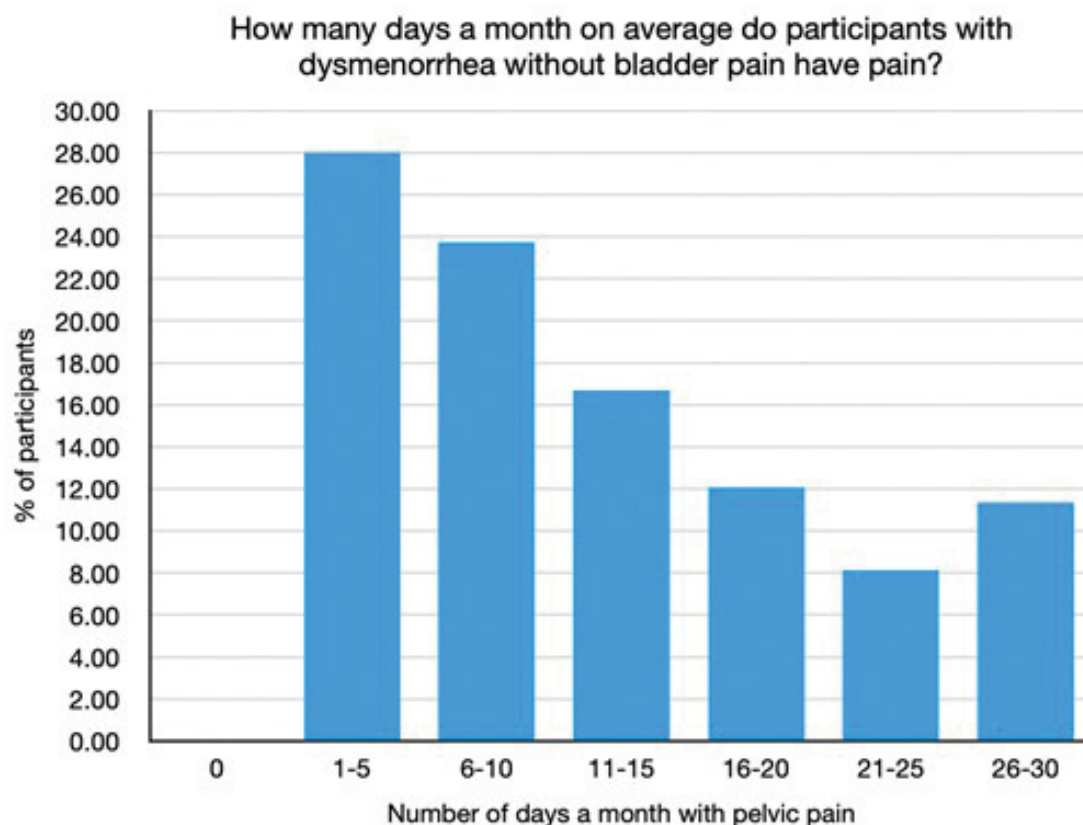
We surveyed 1034 women in Australia and New Zealand through an online platform to allow them to describe their pain, using both structured check boxes and free-form input boxes for them to express their pain in their own words. Ethics approval was granted from the University of Adelaide. We asked what the pain felt like and how such pains affected their lives. We collected over 300,000 words in these responses.

Collating different survey responses, we now know that stabbing pains are highly associated with more severe dysmenorrhoea, more days with pain each month, have a more severe impact on a woman's quality of life, and can lead to a higher level of depression, anxiety and stress.

How many days a month on average do participants with dysmenorrhea and bladder pain have pain?







We also know that certain types of pain are commonly associated with each other, for example, the association of dysmenorrhea with bladder pain. Our survey showed that women with both dysmenorrhea and bladder symptoms have more pain on more days each month compared to their counterparts without bladder symptoms.<sup>12</sup>

There is also a correlation of pelvic pain with the most common terms used to describe it. Of the 468 women with both dysmenorrhea and bladder pain, 419 women described their pain as *stabbing*. *Stabbing* pain has been associated with the presence of a pelvic muscle component to pain. These associations between certain pains are consistent with the consensus view among pain specialists that chronic pain involves central sensitisation and chronic inflammation.

But we can go further than the numbers. The data from the free-form responses to the survey on the language of pelvic pain revealed some strong patterns in the language used to describe pelvic pain. The survey divided pelvic pain into five categories: pain with periods, pain of the vulva, bowel and bladder, and pain with sex. The five overall most common words to describe pelvic pain, in ranked order, were:

PELVIC PAIN: *sharp, stabbing, cramping, ache, dull*

And these were also the most common words (though not in that ranked order) for period pain: the ranked order for period pain was: *cramping, sharp, stabbing, dull, ache*. Period pain, if you will, is closest to the stereotypical model for pelvic pain. But bowel pain did not rate *ache* and *dull* in the top five. Its ranked order was:

BOWEL PAIN: *sharp, stabbing, cramping, burning, intense*

Nor did bladder pain include *dull*:

BLADDER PAIN: *sharp, ache, aching, burning, constant*

What is important is not only the presence of individual pain descriptors, since both bowel and bladder pain lack *dull* in their top five. We can see here the beginnings of a symptom-specific approach to using language for diagnosing different aspects of pelvic pain, but one where single-word approaches will have to be supplemented by multiple-word pain profiles. The triangulation between statistics and qualitative language data, combined with tactile, mechanical and biochemical information, may provide a level of definition which is currently not possible.

#### Beyond the single-word diagnostic tool

These preliminary results point clearly to potential applications in medical diagnosis. Thus far we have concentrated on single-word characterisations of varieties of pelvic pain. We do not expect to discover unique pain descriptors that will point uniquely to specific aspects, lesions, or symptoms of pain. But we do expect, on the basis of research already completed, that there will be patterns of language use that are indeed indicative of the presence of certain types of pain, enabling better identification, consideration and diagnosis for women with chronic pelvic pain. There is evidence, in our data, that single-word pain characterisations are powerfully enhanced, in the pain descriptions, by women who extend their pain language into the expressive properties of phrases, similes, metaphors and more. And these

characterisations of pain require the rich language-based channel of communication with which we began this paper. These narratives and conversations, if fully pursued, should help to establish a channel of communication between the physician and the patient; to build empathy and trust; to enhance the chances of an appropriate diagnosis; and to support the formulation of management plans, especially for chronic pain conditions in women.

## Conclusion

In this endeavour, we have a strong holistic focus on the quality of life of women with pelvic pain. We wish to improve the understanding between women and their health practitioners that facilitates the understanding and management of pelvic pain for both women and their treating health practitioner. For this purpose, the role of language and communication is fundamental.

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# Pelvic pain experience: to be believed and heard



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Language is a powerful tool. It can be used to educate and empower. It can be used to disempower and silence. The language used to describe women with pelvic pain has a dark history steeped in stigma and silence. The stories I hear at our support group tell me we have a long way to go before women are seen, believed and heard.

'For most of history there has been a widely held notion that women are irrational and brimming with uncontrollable emotions and bodily functions.'<sup>1</sup> From the beginning of medicine, the womb was blamed for almost any illness that occurred to women, many of them were labelled as having their origin in hysteria. The word hysteria comes from the Latin word *hystericus* (of the womb). The condition of hysteria was thought to be exclusive to women that would send them uncontrollably and neurotically insane due to a dysfunction in the uterus. The cure was often brutal surgery to remove the uterus (which is still called a hysterectomy today).<sup>1</sup> Dr Kate Young, a researcher, found that even today when women persist with their doctors after all available tools have been exhausted, the hysterical narrative begins to re-emerge.<sup>2</sup>

Some women also know shockingly little about their anatomy. They are not equipped with the language to describe their bodies or the processes that they undergo. This makes it very difficult to accurately describe symptoms and pain to a doctor. In our culture, we don't use the correct words for female anatomy, and female anatomy is often used as derogatory slang.<sup>1</sup>

Dr Young sums up the dilemma of women's sexuality today, 'medical texts have historically constructed women's sexuality as volatile and in need to control; uncontrolled, it would lure men from their intellectual pursuits and distract women from their

assigned reproductive role, it is necessary for them to engage in (penis-vaginal) sex with men. Thus, women are expected to endure but not enjoy sex, and the physical ability to do so became medically pathologized whilst little to no consideration was given to their sexual pleasure.'<sup>2</sup>

Labelling all women with persistent pain as hysterical and blaming their uterus has been the perfect recipe to silence women. Furthermore, not teaching women about their bodies has been another powerful weapon to disempower women. It is very difficult to raise an issue when you don't have the language to describe the problem, and know that you'll probably be labelled hysterical if you do. As a society we still have the prevailing attitude that painful periods are part of being a woman, and painful sex should be endured.

I know the power of language and being silenced firsthand. I experienced a 17-year diagnosis delay. I still live with the impact of 17 years of being told there was nothing wrong with me, that I was making the pain up. Even now, if I ever need to go to hospital, the words that I heard behind hospital curtains across those 17 years bounce around my head with the same clarity as the days that I heard them. I now have confirmation that I wasn't crazy and it wasn't all in my head, but language is powerful. I believed for a long time that there was something fundamentally and psychiatrically wrong with me.

A few years ago, when I went into early labour, I drove myself into my scheduled doctor's appointment. My stomach was huge physical evidence of why I had pain. I was at the end of my pregnancy. But those words came back to haunt me. I was in an internal wrestle all afternoon about whether my labour pains were real or not. I know from my training that what I was experiencing is medical trauma. When I made it to my doctor and they asked why I didn't call, I just stared and blinked. Still in the freeze state unable to speak my truth about the fear that I wasn't actually in labour and maybe I was just making it all up.

Soon after that, something was born in me too. An itching or inkling that I had to find my voice so that others would not be silenced. I had researched a lot over the 17 years that I didn't have a diagnosis. I didn't have the right words to find what I was looking for. I didn't have the language to ask for help, and for many years I gave up asking and searching because I was resigned to the fact that whatever was wrong with me was somehow my fault.

I started to read everything I could about endometriosis, pelvic pain and chronic pain. I wanted to understand if you could live well with pelvic pain, and why my story was so common. I am forever grateful for books like *Endometriosis and Pelvic Pain*<sup>3</sup> and *Pain and Prejudice*<sup>1</sup> which not only gave me the language to describe my experience but gave me the support that I needed. Those books helped me feel seen and believed.

The first time I spoke publicly about my experience with endometriosis was unexpectedly confronting. I hadn't thought about the fact that I had never really talked openly about my experience. I hadn't really thought about how strongly that belief that maybe I was crazy remained. Until that day, I had lived by denying and underplaying my story. As Brené Brown says 'Owning our story and loving ourselves through that process is the bravest thing we'll ever do.'<sup>4</sup> Standing up and owning my story was one of the hardest things I have done. Owning the fear and the trauma and not minimising it empowered me and the women in the room who heard it.

I now run a support group for people with endometriosis, adenomyosis, PCOS and any other type of pelvic pain. A key component of the group is to provide a safe space for women to find the language and their voice to describe what has happened to them. We have professionals come and talk so that women can ask questions in a safe environment. No topic is off limits, and all attendees are encouraged to be open and share their experience.

I now tell my story and stories of others on an almost weekly basis. I have the language to describe the lived experience of women with pelvic pain, and the research statistics to back up their stories. I have no qualms about talking about menstruation, or painful sex. It took practice but it is now part of my everyday vocabulary. I use this combination when speaking with journalists, 'Endo Warriors' and politicians.

I am passionate about changing this space. I will work in this space for as long as I can and have conversations about women's pain and sexuality. It amazes me that 800,000 people in Australia

alone have endometriosis, making it as common as asthma and diabetes, and yet it has received so little recognition and funding to date. How do we unite these women? How do we empower them to rise up as a collective and use their voices to say, this isn't good enough? I can't see any negatives to empowering women to understand more about their bodies and to be able to get help before their pain becomes disabling and chronic.

I live with the scars of how much language can hurt, and how powerful it can be in silencing and shaming a person. I would argue that every woman lives with the hurt and coercive control that language has had over our bodies and reproductive health. I have also seen how powerful language can be in empowering and uplifting people to live their best lives. Language is a powerful tool that can literally change a person's life.

I encourage you to think about how you use language to talk to those with pelvic pain, to describe those with pelvic pain, and to describe the pain itself. Check your own bias and language, and think about how you can empower those with pelvic pain to live well and find their voice.

Three of the most powerful words you can use to start any conversation with someone with pelvic pain are: I believe you.

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# The language of pathology

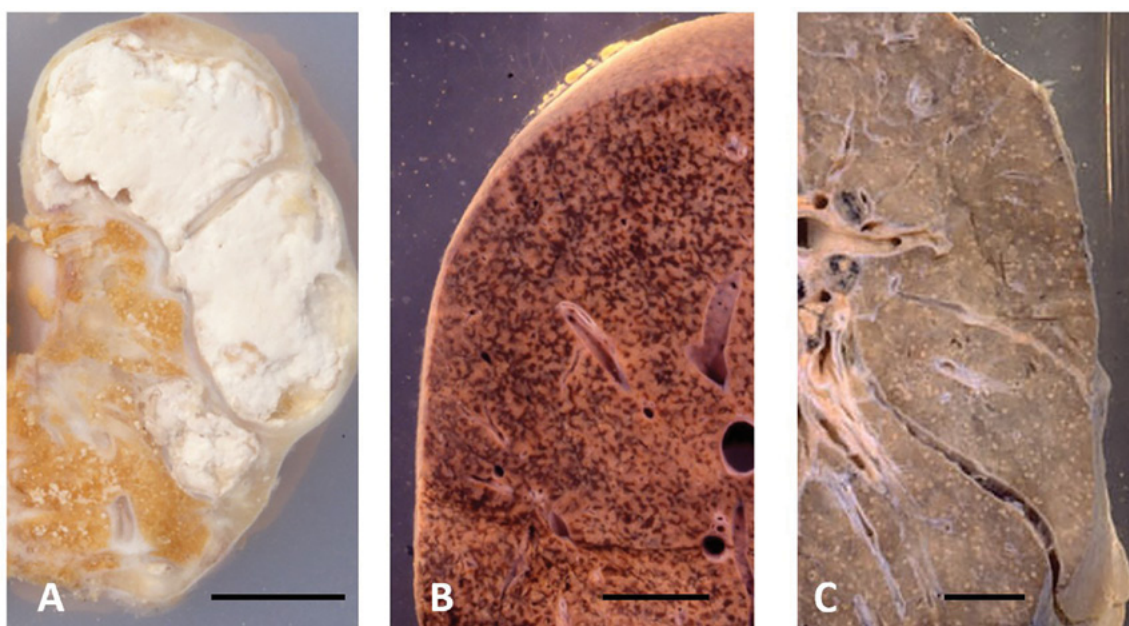


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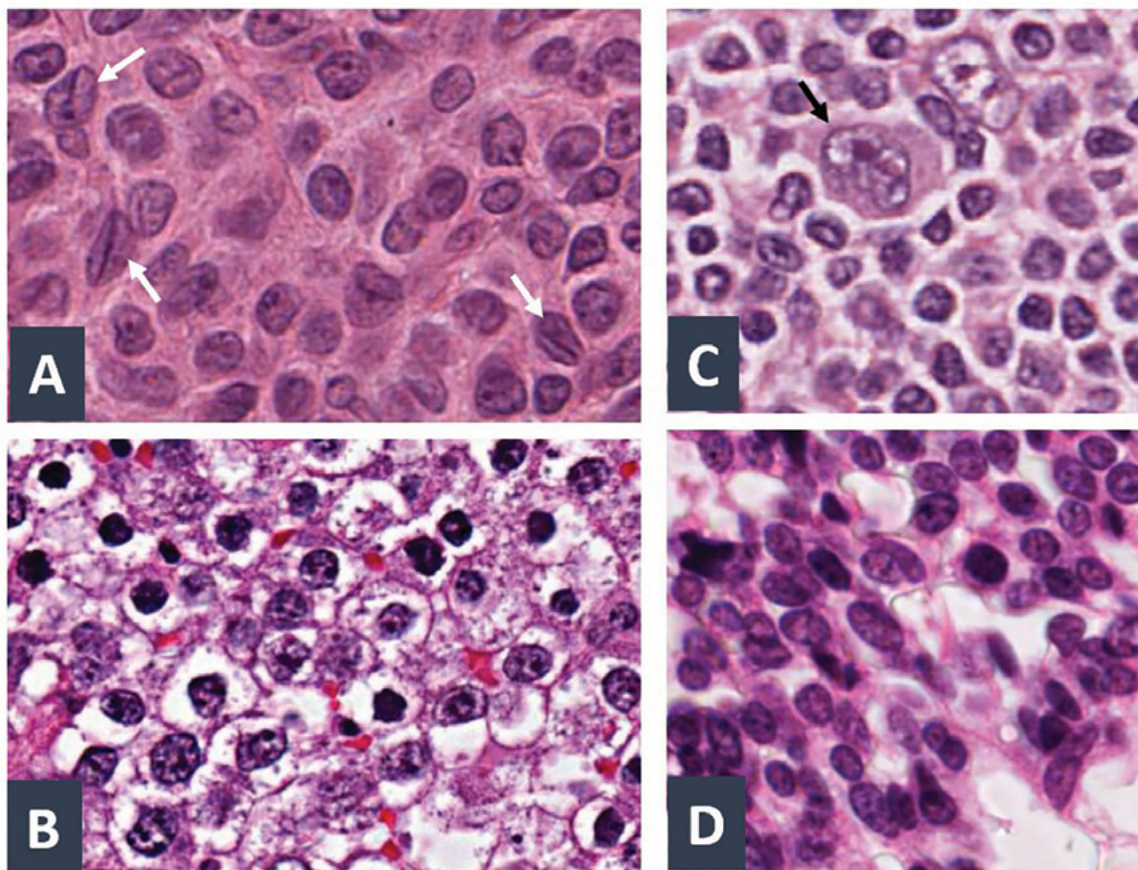
Almost every area of medical practice displays some uniquely idiosyncratic use of language. However, it's likely that pathology has the largest collection of curious culinary expressions, which most practitioners probably recall from their student days. Once upon a time, it was an annual ritual for medical students to concoct the best possible menu from pathology 'ingredients' ... anchovy sauce pus or currant jelly clots, anyone?

Some of the quaint food/cookbook terms refer to macroscopic appearances such as the 'cheesy' (feta, not cheddar!) appearance of caseous necrosis in tuberculosis (Figure 1A). Others describe microscopic patterns such as 'coffee bean' nuclei in granulosa cell tumours (Figure 2A). Many of these archaic descriptions are sufficiently odd that they are at least memorable, so they serve some educational purpose. However, a number make little sense these days, especially to urban medical students. UNSW graduates might recall that the university's Museum of Human Disease has a specimen of the polished surface of a cut nutmeg next to a specimen of chronic passive venous congestion of the liver, to help explain the origins of the term 'nutmeg liver' (Figure 1B). Or they might remember a specimen of millet seeds, relevant to the phrase 'miliary tuberculosis' which is still used to indicate the size of the individual lesions in massive haematogenous dissemination of tuberculosis (Figure 1C).

Food-related descriptions of pathological changes were reviewed in an article in the *BMJ* over 40 years ago.<sup>1</sup> More recently, a list of food-related terms used across a variety of areas of clinical practice was reported in the *American Journal of Medicine*.<sup>2</sup> This seemed to suggest that ophthalmology might be almost as enthusiastic about culinary comparisons as pathology! In another recent article, the authors compiled a glossary of over 100 food-related terms used in medical practice.<sup>3</sup>



**Figure 1.** Macroscopic specimens illustrating changes traditionally described using food-related terminology: (A) severe renal tuberculosis demonstrating replacement of the parenchyma of the kidney by white, crumbly necrotic material, described as 'cheesy' or caseous necrosis. (B) chronic passive venous congestion of the liver, for which the time-hallowed descriptor is 'nutmeg liver'. (C) hundreds of ~1mm 'miliary' lesions distributed throughout the lung parenchyma in massive haematogenous dissemination of tuberculosis. Bar = 25 mm.



**Figure 2.** High-magnification photomicrographs illustrating cell nuclei traditionally described using food-related terminology: (A) 'coffee bean' nuclei in a granulosa cell tumour – the longitudinal groove in some of the nuclei (white arrows) yields an appearance thought to resemble a coffee bean. (B) 'fried egg' nuclei in a seminoma of the testis. (C) 'popcorn' nucleus (black arrow) of a malignant cell in lymphocytic predominance Hodgkin's lymphoma. (D) hyperchromatic nuclei in cells with a high nucleus:cytoplasm ratio in small cell anaplastic carcinoma of the lung, thought to resemble oat grains, hence the designation 'oat cell' carcinoma.

Nevertheless, the inclusion of food-related terms in internationally distributed textbooks can be a source of much confusion, notably for students in parts of the world where the foods being referred to are not grown or consumed. As was pointed out in an article published some 20 years ago, 'strawberry haemangioma' conveys little meaning to an African medical student who has never seen a strawberry.<sup>4</sup>

Perhaps the time has come to think about the language of pathology in modern terms, rather than romanticising 'bread-and-butter pericarditis' or 'sugar-icing spleen'. Pathologists are first and foremost the scientists of medical practice, who take pride in their laboratories being able to perform diagnostic assessments with precision and reproducibility – something for which we can be very grateful in these COVID-afflicted times. Ongoing discussions about COVID mean that terminology related to the modelling of epidemics has probably found its way into your everyday language. However, many medical practitioners still do not think of the sensitivity and specificity of diagnostic tests, or of

their positive and negative predictive values, as fundamental to the practice of medicine and the interpretation of reports provided by pathologists. We should.

While we are on this topic, I would like to mention my pet peeve with respect to the use of language *about* pathology. Please don't let me ever hear you ask about 'the pathology in this patient'. Pathology is a science, not a disease. There is an abnormality, a pathological process, a disease, a lesion or lesions ... but unless the patient has swallowed a copy of a textbook, there is no pathology *in* the patient!

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# Our words matter – now more than ever



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Language is a powerful medium, both written words, and probably more importantly in maternity care, our spoken words. The words we choose to use or not use is complex and not always well thought through, especially in stressful situations. As a midwife, I have had my fair share of getting it wrong over many years – and I suspect I still do from time to time. Now, behind a mask, a face shield and sometimes in full personal protection equipment (PPE), it can feel even harder. Receiving feedback from, and through, facial expressions is also more difficult. So, I write this in full acknowledgement of the challenges faced in the sector, especially at the moment, and I suspect minding our language is possibly not high on the list of priorities for many – and understandably so. However, there is no doubt that language matters and probably more so than ever at this time when women's experience of maternity is so altered in so many ways due to COVID-19 restrictions and challenges.<sup>1</sup> Women receiving maternity care, more than ever, need to be informed, empowered, supported and enabled. The words we use can assist women to have a positive experience, but they can also be disempowering and deflating.

When I trained as a midwife, now more than 30 years ago, I confess to not thinking about the words I used or heard others use. I came from a very conventional and hierarchal training as a nurse in a hospital that, looking back, felt more military than healthcare. As a midwifery student, I happily talked about 'my patients', the 'lady (or girl) in room 3', the 'primip in bed 2 who has been ARM'ed', 'my deliveries' and what 'we' were happy to 'allow' women to do. I was desperate to quickly learn and be able to use all the new terminology to fit in. Labelling women with terms like 'failure to progress', the 'incompetent cervix', the 'failed homebirth', the 'failed VBAC', being

'only' 3cm and enthusiastically documenting all these failings in their medical records, ensured I fitted in and did well as a student. I have no idea what the women thought of this – reflecting or debriefing with women or receiving open feedback was not something that was in the culture of the time. In hindsight, I cringe at the thought of so much patronising, power-laden language and so many alleged failings for women to start motherhood carrying.

Fortunately, in the years that followed graduation, I have become a lot more reflective, and hopefully more thoughtful, about the power of language. My friend and colleague, Prof Nicky Leap, first brought these issues to the attention of midwives with her paper 'The Power of Words', published in 1992.<sup>2</sup> Nicky argued that the dynamics of using words like 'allowing' and 'managing', of making sexist innuendos, or jollying women along, belittles and trivialises them and their experiences. She challenged midwives to rethink the words we used – at the simplest level, acknowledging that it was the woman who gave birth, rather than us delivering them and reframing all the failures. In 2012, Nicky re-visited the piece again highlighting the potential impact of the words, especially the way words manifest power in any situation.<sup>3</sup> She argues that word choice is a deeply political process that challenges us to consider inequalities, particularly those associated with sexism, racism, class and homophobia.

The words we use reflects the power dynamics and values of our culture and our heritage – personally and professionally. In maternity care, the words we use can also perpetuate hierarchies and contribute to a lack of shared decision making with women. Our love in healthcare of abbreviations and acronyms is one example of further distancing women from shared understandings and ensuring that we, as the provider, remain in charge. When we write and say things like VBAC, ARM, IUGR, VTE, PE and dozens of other examples, we speak in code and this usually means the women we attend are kept in the dark. Terms of endearment are another difficult area that I feel have reduced in usage somewhat but I am sure still exist in some contexts. Well-meaning terms such as 'dear' or 'love' may make one woman feel cherished and another woman shrink away from us as she grapples with what she sees as inappropriate or patronising familiarity.

More recently, I have also argued that we need to rethink the words that we use in terms of stillbirth, both in practice and in academic writing.<sup>4</sup> Women, their partners and families who experience stillbirth are equally impacted by the words we use and, in many instances, these words stay with them forever as there are no new memories of a baby growing up to replace those words. Terms such as fresh stillbirths and macerated stillbirths can feel brutal and dehumanising – especially to a bereaved family.



Rethinking how to express stillbirth in a respectful and kind way is needed – perhaps referring to the timing of the death – a stillbirth during pregnancy, or one that occurred in labour is better?

Another topical area is use of the word 'vulnerable'. In the COVID-19 era, this word is used a lot, especially describing groups who have inequitable access to services, care and vaccination as well as those disproportionately impacted by lockdowns and other restrictions. Colleagues and I have also recently challenged the use of this word in an effort to reframe the focus.<sup>5</sup> In this piece, we argue that deficit terms like vulnerable can conceal wider structural causes that lead to health inequities and obscure accountability of those responsible for generating or perseverating these causes and structural power imbalances. Outlining the characteristics and circumstances that may give rise to vulnerability refocuses the issue to a wider system of issues that need to be addressed.

In the last 30 years, one area that maternity care providers have done well is to recognise that the women we attend are not necessarily 'patients' or want to be referred to as such. Most maternity care providers, hospitals and health systems are now very thoughtful about referring to women and shifting the power balance from a potentially 'helpless' patient to an informed and engaged woman as being central to the care. Woman-centred care is firmly entrenched as a fundamental philosophy and approach in maternity care in policy<sup>6</sup> and practice.<sup>7</sup> It is therefore disturbing that there is a move to make women invisible with terms such as 'pregnant and birthing people'. I have previously written about this in *Women and Birth*, recognising and respecting the increasing rejection of a binary approach to sex and gender and I also know that Trans and gender diverse people face substantial injustices, including violence and discrimination.<sup>8</sup> Of course, when caring for individuals it is essential to use the person's preferred personal pronouns and words that are acceptable to them. However, at a population or collective level, I find it very difficult (actually impossible) to erase the words 'woman and women' given the years of struggle to reduce marginalisation, highlight gender inequities and remove invisibility. I will still keep talking about, and writing about, woman and women especially in relation to maternity care.

Deciding which words we will try not to use is not straightforward. It is difficult to stop using words and phrases that are entrenched in everyday maternity practice, in our electronic records and in the terminology that surrounds us in conversation, documentation and signage. Changing long-standing traditions and accepted words and phrases is hard and takes courage. Being the word police is also not fun so we need to find acceptable and sometimes light-hearted ways of influencing change. Helping people identify words that they might choose to change needs to also be done with kindness and generosity of spirit and we cannot, and must not, resort to humiliation, belittling or bullying.

For all of us, no matter our cultural origins or perspectives, words inevitably provoke a myriad of meanings and can cause us to question our own values, belief structures and ways of being.<sup>3</sup> Ultimately though, being open to change and being brave enough to reflect with women, their families and with our colleagues can only help our learning about the impact of the words we use and working out how best to move forward in a positive way.

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# Those birthing people, they're women



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In 2014, Milli Hill was in the news because Facebook had removed photos of her childbirth and given her a three-day ban on the grounds that posting them 'violated community standards'. Both *news.com.au* and *The Guardian* ran stories publishing the photos, and they used the headlines 'Facebook censors photos of women giving birth'<sup>1</sup> and 'By removing photos of childbirth, Facebook is censoring powerful female images'<sup>2</sup> respectively. Fast-forward nearly seven years and Hill is in the news again, protesting not the suppression of images of women, but the suppression of language referring to women.

In response to an Instagram post about obstetric violence against 'birthing people', Hill had responded '...obstetric violence is violence against women. Let's not forget who the oppressed are here, and why'. Her response blew up on social media, and she was subjected to a slew of abusive comments including that she was 'trash', 'toxic', 'poison', 'anti-LGBTQ', and 'transphobic'. Hill told *The Times* that it wasn't 'random trolls' making these comments about her, but 'doulas, hypnobirthing teachers, antenatal teachers, midwives, birth trauma specialists'. The charity Birthrights severed its relationship with her, and professional contacts distanced themselves.<sup>3</sup> More than 2000 people signed a petition asking the New Zealand College of Midwives to remove Hill as a keynote speaker, describing her as a 'known transphobic writer'.<sup>4</sup>

What explains this response? When the women's liberation movement kicked off, it was seen as vitally important to name male violence against women and girls for exactly what it was. Such violence is

patterned, disproportionately perpetrated by men against women. The people who objected to this sixty years ago, and said 'but women can be violent too', were men's rights activists, not progressives. Today, many are progressives. So what's changed?

What has changed is that naming obstetric violence as (male) violence against women instead of against people is to make reference to what some progressives would like to make unsayable, namely the reality of biological sex, the link between femaleness and pregnancy. In naming a truth perfectly obvious to everyone since we developed the language, as a species, to name such things, Hill was also dissenting from a new orthodoxy: the ideology of gender identity.

The new orthodoxy denies the reality of biological sex and claims that it is a mere 'social construct'; believes in gender identities—subjective inner identifications with one sex/gender or the other, or neither (it is often unclear what exactly is being identified with); insists that everyone has a gender identity; believes that for all legal purposes, it is a person's gender identity, not her sex, that should determine her treatment, and her legal rights. This set of beliefs has gained swift social acceptance, due to the widespread allegation that questioning any part of it is 'transphobic' and 'exclusionary'. It has gained extraordinarily rapid legal entrenchment, too: Victoria, for example, has already made it the case that any person can change her legal sex by statutory declaration (sex self-ID); and that adults (with a few exceptions) are at risk from legal action if they engage in practices that 'change or suppress' someone's gender identity (conversion therapy). Victoria is also expected to soon introduce legislation that extends vilification protections to 'gender identity' as a protected attribute, even though the state's definition of gender identity is so vague as to include almost everything. 'Gender identity means a person's gender-related identity, which may or may not correspond with their designated sex at birth, and includes the personal sense of the body (whether this involves medical intervention or not) and other expressions of gender, including dress, speech, mannerisms, names and personal references' (p. 39).<sup>5</sup>

The ACT and Queensland have versions of the conversion therapy legislation in place; Tasmania has sex self-ID, and the ACT, South Australia, and the Northern Territory require only 'clinical treatment' before a legal change of sex, which can be as little as a few counselling sessions.

Thus, we land in a situation in which naming the realities of femaleness and maleness is considered unacceptable; in which we must make all biological issues 'sex-neutral' so as not to exclude anyone

who doesn't identify as their biological sex (some nonbinary people), or who identifies as the opposite sex (some binary trans people) [I say 'some' because not all people who claim gender identities deny their biological sex, but many do]. Alexandria Ocasio-Cortez recently tweeted that 'The gutting of Roe v Wade imperils every menstruating person'.<sup>6</sup> Women and girls menstruate; Ocasio-Cortez is writing in the new orthodoxy on the grounds that someone biologically female with a 'man' or 'nonbinary' gender identity might menstruate. A parenting website dealing with periods refers only to 'children' getting their periods,<sup>7</sup> as though this is something that could happen to any child. The Australian Department of Health retitled its vaccination decision guide for 'women who are pregnant, breastfeeding or planning pregnancy' to being for 'people who are pregnant, breastfeeding or planning pregnancy'.<sup>8</sup>

In a male-dominated society, which ours is (and is marked by the legacy of being such), 'gender-neutral' language risks being androcentric language. The default human is male, so if we don't specify that she is female, and draw attention to her femaleness in order to insist upon female representation, our gender-neutral human will be male. Second-wave feminists Mary Daly and Marilyn Frye helped to reveal this. Their example was 'man', allegedly referring to all of humanity, but revealed to refer to men by way of the dissonant phrases 'the sisterhood of man' (Daly, 1973), and 'female man' (Frye, 1983). More recently, in her book *Invisible Women* (2019) Caroline Criado-Perez revealed countless examples of androcentrism throughout medicine, town-planning, product design and more. The 'default male' is responsible for health apps that don't track periods, bullet-proof vests that don't fit around women's breasts, and snow-ploughing that leads to more accidents for young mothers.

This all makes it particularly distressing that it is often women at the forefront of the movement to erase women-centred language. Those women may have good intentions: the inclusion of people with cross-sex or no-sex gender identities. But the conversation is constantly framed as though it is a matter of inclusion versus bigotry, a matter of respecting trans people versus being a 'transphobe'. It isn't. Considerations against gender-neutral language for female-specific health issues include the history of struggle for women's representation in language, which our feminist foremothers fought hard to win; the fact that inclusion is not the only value that matters; and the fact that even if it was, including trans people may come at the cost of excluding some women, such as women for whom English is not their first language, and who do not understand that they are 'menstruating persons', 'cervix-havers', 'people who are pregnant', 'children who will get a period', etc.

The most vivid example of what we lose in the shift to gender-neutral language can be seen when we consider domestic violence. This is disproportionately an issue of male violence against female people. There is occasionally domestic violence between men (in gay couples) and between women (in lesbian couples), as well as between people of different gender identities whatever their sex. But if we recast

domestic violence as an issue of violence 'by people against people' an incredibly significant piece of information would be lost. For it is not people who are disproportionately the perpetrators of domestic violence, but men (males); and it is not people who are disproportionately the victims of domestic violence, but women (females).

The problem might seem less drastic in the case of terms like 'people who are pregnant', 'birthing persons', or 'menstruating persons', where at least there is a clear reference to female biology with the references to pregnancy, birth, and menstruation. But concessions here are still dangerous, for they take us one step closer to the erasure of women in language and a return to the default male. There are better alternatives that don't take this risk, and that take a clear stand against allowing women to become invisible in language once more. Our concern should be to centre women, while also making sure that female people who don't identify as women know they're included. We can do this with phrases like 'women and trans men', 'women and other people who give birth', 'women and others who menstruate'.

The objection to this is likely to come from transwomen, not trans men, who object that 'not all women!' get pregnant, give birth, breastfeed, menstruate. This objection ought to be ignored. It is based on a misunderstanding, an assumption that something is not a women's issue unless it is an all-women issue. But virtually nothing is an all-women issue. It was never the case that all women were assumed to get pregnant, give birth, breastfeed, menstruate. That doesn't mean these aren't women's issues. We don't need to take a stand on the contestation of the term 'woman' between being a sex or a gender identity to grant this point. Whether or not transwomen are women, pregnancy is a women's issue, and we need to retain the language to talk about that fact.

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# Update on the RANZCOG Communication Skills Training Workshop



**Dr Pradeep Ruba**  
Junior doctor,  
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In November 2019, following feedback from the Trainees Committee, the College Education Strategy Committee approved a recommendation to update our formal training on communication skills. Prior to that, training was delivered by an external agency, and the decision was taken to develop an in-house Communication Skills Workshop, tailored to our own specific needs as a professional group. Work on that project began in 2020, and the new course has been piloted this year.

An essential component of the design of the new workshop was feedback from our junior workforce around areas of communication that they find difficult. In this article, Dr Pradeep Ruba, a junior doctor in obstetrics and gynaecology in Perth, raises some of the key issues presented in trainee feedback, and we discuss how the new workshop has sought to address those concerns.

## Pradeep

Good communication skills are vital in our daily life as doctors, and a key component to reducing errors and ensuring patient safety is promoting good communication with patients and effective communication between healthcare professionals. Will the new course aim to improve doctor-patient communication as well as communication between healthcare professionals?



**Dr Katrina Calvert**  
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on behalf of the RANZCOG Communication Skills  
Workshop Redevelopment Group

## Response

The new Communication Skills Workshop has been designed with two separate modules: communication with patients and communication with colleagues. Although many communication skills cross both of those domains, we wanted to highlight that the challenges trainees face in those two arenas can be different, and to present the course participants with opportunities to discuss their own experiences in both. The new course incorporates some useful strategies and tips, and gives the trainees the opportunity to practice some specific scenarios in both patient and colleague communication.

**Pradeep**

Breaking bad news is a skill that is relevant in all fields of medicine, but in obstetrics it can be particularly challenging. The expectations of the parents are that they will leave hospital with a healthy baby. However, this is not the case when, for example, a diagnosis of stillbirth is made. How the diagnosis of stillbirth is communicated has a profound and long-term impact on parents, who value open, sensitive and honest communication with an emphasis on language and environment. The care parents receive at the time of perinatal bereavement can shape their entire grieving process and negative experiences can worsen what is already an incredibly difficult time. Junior doctors can also experience added difficulty when the diagnosis of stillbirth is not 100% certain and follow-up imaging is required. Does the new course address breaking bad news in situations specific to obstetrics?

**Response**

Everyone finds breaking bad news difficult, and trainees often have anxieties around their ability to do this. The updated workshop discusses breaking bad news in both obstetric and gynaecological settings, provides some useful mnemonics to help structure these sorts of conversations, and gives the course participants a chance to reflect on their own experiences in this area. The course also includes an opportunity to practice these skills in a safe way using roleplay. Feedback from the pilot courses has suggested that, whilst not everyone enjoys roleplay, the trainees find these discussions very useful – particularly the opportunity to share their own experiences.

**Pradeep**

What about the difficult situation of communicating with a patient who does not want to follow our advice? Pregnancy and birth are not usually pathological processes requiring medical care, and sometimes the advice we give may not be acceptable to an expectant mother. Conveying our concerns often requires high-level interpersonal and communication skills since there is often no good evidence to recommend a particular management option over another. Junior doctors can find this a particularly difficult area – will the course cover this?

**Response**

One of the key areas covered in the workshop is how to address patient expectations. The course covers some of the key components of effective communication, including how to assess what the patient wants to know, and how to explore emotional responses. We have used videos which have been scripted and filmed by junior doctors, so that the scenarios used to scaffold these discussions are both familiar and relevant to the workshop participants.

**Pradeep**

There are many barriers to effective communication including time constraints and understaffing. Source

credibility is a barrier to effective communication as it highlights the importance of the trainees' knowledge, experience, and interpersonal skills when delivering information and counselling patients. The many preconceived ideas and expectations patients have may also pose as barriers to effective communication with patients. For example, the firm expectation of an uncomplicated vaginal birth of a 4.5kg fetus may hamper efforts to counsel women on making an informed decision about mode of delivery. Does the course cover overcoming these barriers to effective communication?

**Response**

The new course has some great resources around the topic of barriers to communication. There is a lot to cover in this area, so the workshop includes some pre-reading that acts as a trigger for the opening discussions during the course. Trainees bring their own perspectives and the pilot workshops have included some really insightful reflections from the trainees around the barriers they perceive, and how they have worked to overcome them.

**Pradeep**

Hierarchy is very apparent in the medical profession and junior doctors have expressed difficulty raising concerns about patient management for example, to senior colleagues who may not always receive this well. Does the course provide tools to equip trainees with the confidence to appropriately escalate their concerns if required?

**Response**

The new workshop covers lots of different areas around communication with colleagues, including some tools that can be used to frame conversations where graded escalation is required. The course takes participants through several scenarios, where they are required to lead a difficult conversation (for example, in giving negative feedback), or where they are required to respond to a challenging communication (for example, dealing with aggression). Again, new resources including videos scripted and created by junior doctors have been developed, really putting the trainee experience at the centre of the learning experience.

**Conclusion**

The updated Communications Skills Workshop has been piloted with two groups of online participants including first- and second-year trainees from around Australia and facilitated by Jenny Beale, Katrina Calvert, Jeremy Chin and Tim Hasted. We are currently looking at the course evaluations and feedback for the pilot, in order to make sure that the course is meeting the needs of our trainees before we roll it out officially. The Communication Skills Workshop development team will continue to actively seek the input of the most important group in determining the future direction of this training – the junior doctors at whom the training is targeted.



# Introduction of new technology into practice



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During recent history, the practice of gynaecology has evolved at a rapid rate due to: the steady introduction of new technology; the provider's eagerness to be at the cutting edge; and the consumer's expectation that 'new things are always better than old things'.<sup>1</sup> However, unlike new medications, the adoption of new technology has remained largely unregulated, is often not subjected to the same rigorous scientific assessment and regulatory oversight, and may at times be spruiked by inventors who are key opinion leaders and manufacturers, with vested commercial interests.<sup>2</sup> In this context, it is essential to recognise that neither healthcare providers nor consumers may fully understand the benefits and risks of new therapeutic options. Nonetheless, consumer safety remains the ethical and legal responsibility of the provider; hence, when embracing new technology, gynaecologists must be astute in differentiating between beneficial technological changes, and those that may cause harm.<sup>3</sup>

In this article, we will clarify the definition of 'new technology', and identify key considerations when deciding: whether and when to introduce a new technology into clinical practice; how to obtain informed consent around the proposed treatment; the potential benefits, material risks and consequences without adequate supporting evidence; and what should be done after adoption to ensure patient safety.<sup>4</sup>

## Definition of new technology

In the medical context, 'technology' refers to a drug, device, procedure, technique, or process of care. The Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) considers 'technology' to be synonymous with devices, and 'technique' synonymous with procedures, and further sub-defines 'new' or 'modified' devices or procedures as follows:<sup>5</sup>

- **New device:** product of disruptive innovation, or a device that has not been previously used by the surgeon (eg. the use of transvaginal synthetic mesh for prolapse repair).<sup>6</sup>
- **Modified device:** existing device the surgeon has experience with, that has been altered to improve functionality or performance (eg. upgrade of an advanced energy device, which delivers increased sealing speed).<sup>7</sup>
- **New procedure:** novel technique that differs dramatically from what the surgeon is used to, or a technique not previously used by the surgeon (eg. platelet rich plasma for stress urinary incontinence).<sup>8</sup>
- **Modified procedure:** modification of a known procedure or technique, with which the surgeon is familiar (eg. vaginal natural orifice transluminal endoscopic surgery hysterectomy, instead of vaginal hysterectomy).<sup>9</sup>

## Key questions

When considering introducing new technology into practice, clinicians should ask the following key questions:

### Has the new technology been adequately tested for safety and efficacy?

Ideally, there should be robust data regarding safety, efficacy, and effectiveness of new technology before its introduction into clinical practice. However, evaluating new technology is a complex process for which there is no universal agreement regarding the evaluation pathways for generating and analysing data throughout its life cycle. Furthermore, objective assessment of a new technology is often complicated by clinical idiosyncrasies such as: procedural modifications by surgeons during development; lack of agreed outcomes; learning curves; variable training; variable operative capabilities; and patient and clinician treatment preferences. In addition, data from surgical trials may provide evidence suggesting short-term efficacy, yet fail to answer questions regarding long-term safety.<sup>10</sup>

A recent example is transvaginal mesh for the management of prolapse: early data suggested superior efficacy to native tissue repair, and led to its widespread adoption. Subsequent reports of mesh-related erosion and chronic pain led to medico-legal controversy, public enquiries, regulatory withdrawal, and manufacturer discontinuation of this once-promising technology from the pelvic floor surgical armamentarium.<sup>11</sup>

To help overcome the challenges in evaluating new technology, the Balliol Collaboration team proposed a five-stage process called 'IDEAL'. Standing for Idea, Development, Exploration, Assessment, and Long-term study, the framework emphasises appropriate methods, data transparency, and the rigorous reporting of outcomes when evaluating new technology.<sup>12</sup> It also recommends the widespread use of prospective databases, and anonymous reporting of adverse outcomes to professional registries. Despite gaining significant traction within academia, whether the IDEAL framework will be routinely adopted prior to the introduction of any new technology into clinical practice remains to be seen.<sup>13</sup>

### **Is the new technology as safe and effective as existing, proven techniques?**

When adopting a new technology or technique, its safety and effectiveness must be compared to the existing gold standard. Consider the adoption of minimally invasive hysterectomy for benign pathology: the eVALuate study involved two parallel randomised trials, one comparing laparoscopic hysterectomy (LH) with abdominal hysterectomy, the other comparing LH with vaginal hysterectomy (VH).<sup>14</sup> This landmark trial concluded that LH (when compared to abdominal hysterectomy) was associated with a significantly higher rate of major complications (lower urinary tract injury) and took longer to perform, yet was associated with less pain, quicker recovery, and better short-term quality of life. Taking these nuanced results into account, ACOG concluded that (when VH is not feasible) LH should be performed rather than abdominal hysterectomy.<sup>15</sup>

Regarding LH and malignant pathology: adding to earlier research supporting the safety of LH (over abdominal hysterectomy) for early-stage endometrial cancer,<sup>16</sup> Uppal et al concluded that minimally invasive hysterectomy was superior to abdominal hysterectomy in the management of early cervical cancer.<sup>17</sup> However, later research (the Laparoscopic Approach to Cervical Cancer [LACC] trial,<sup>18</sup>) concluded that laparoscopic radical hysterectomy was associated with worse disease-free and overall survival than an abdominal approach. Hence, the pendulum has swung back towards favouring the traditional open radical hysterectomy for women with early-stage cervical cancer.<sup>19</sup>

The above examples regarding the application of minimally invasive hysterectomy demonstrate the importance of high-quality clinical trials when comparing the safety and effectiveness of new technologies and their older counterparts.

### **Am I adequately qualified to offer the new technology?**

Acquiring the appropriate skills is an absolute pre-requisite before using a new device or performing a new or modified surgical technique; additional criteria must also be met before a clinician can be considered fully qualified.<sup>5</sup> Completing a comprehensive and well-designed educational

program allows clinicians to: understand the relevant disease process(es); select suitable patients and pathologies to employ the new technology; and to recognise and manage any associated complications promptly. Preceptorship of initial cases often proves invaluable during the clinician's early learning curve. In addition, an appropriate ongoing surgical caseload, an adequately trained surgical team, and systems to monitor outcomes and adverse events help practitioners to maintain competency when adopting the use of a new device or technique (eg. minimally invasive sacrocolpopexy).<sup>20</sup>

### **Is the new technology cost effective?**

A cost-benefit analysis should be performed when considering the adoption of new technologies in comparison to established treatment options. Costs associated with a new technology may include the cost(s) of: the device/equipment; educating the clinician and surgical team; and maintenance and/or technical support. Potential cost-savings may include: shortened hospital stay; earlier resumption of work; and reduced healthcare costs in the long term. To monitor ongoing cost effectiveness, it would be necessary to establish and maintain a comparative database, in which outcome measures (including cost analyses) are routinely recorded.

The cost effectiveness of robotic technology in gynaecological surgery is a case in point. An early systematic review and meta-analysis concluded that robotic hysterectomy increased operative costs by 1.5- to 3-fold, with no improvement in any measurable clinical outcome.<sup>21</sup> Another systematic review and meta-analysis found no statistically significant, nor clinically meaningful differences in surgical outcomes and a cost increase of \$1607USD per robotic hysterectomy, if the initial cost outlay of buying the robotic device was gradually written off over its lifespan.<sup>22</sup>

### **What should be discussed with patients when a clinician is considering employing a new device or technique?**

Patients must be informed of all relevant benefits and risks inherent to using a new technology.<sup>23</sup> The exact information disclosed during the consent process depends upon what that particular patient considers to be a material risk. The 2020 NSW Consent to Medical and Healthcare Treatment Manual states that:

... the Health Practitioner must inform the patient that the procedure or treatment is new to their practice and provide the patient with details of their previous (potentially limited) experience with the procedure or treatment as part of the consent process.<sup>24</sup>

This detailed discussion should be documented in the patient's health record, and should include (as relevant):

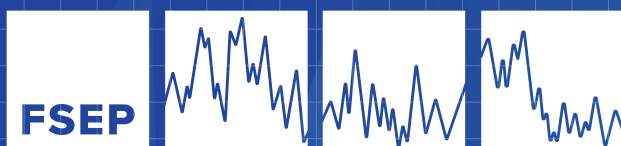
- The potential benefits and risks of the new device / technique, including any gaps in the current evidence base
- The surgeon's relative inexperience
- The surgeon's complication rate(s) thus far
- Uncertainties related to unforeseeable or unknown risks, due to the experimental, unvalidated nature of the device / technique
- Any related out-of-pocket costs the patient may incur

## Conclusion

New technologies have the potential to provide patients with improved clinical outcomes, and surgeons with a competitive edge. However, rather than assuming that 'new things are always better than old things', we should adopt a system which integrates: a stepwise search for solid evidence of safety and efficacy; cost-benefit analyses; quality education and training; and a thorough consent process. Doing so will ensure that the evolution of gynaecological surgery is helped, rather than hindered, by innovative devices and techniques.

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## How do you suppress lactation and when should it be considered?

**Dr Amber Hart**  
BSc, MBBS, FRACGP, DRANZCOG, IBCLC  
Maternal and Infant Wellbeing Melbourne



### Why suppress lactation?

There are various reasons for the need to suppress lactation, ranging from personal choice to urgent necessity. Regardless of the reason, this topic requires a gentle and considered approach, as this can be a very emotional decision for any breastfeeding parent.

Pregnancy or neonatal loss is the most common reason for pharmacological suppression of lactation in the immediate postpartum period, but medication shouldn't be first line in managing this process.

Whenever possible, counselling of the parents prior to the delivery is ideal as some parents find the onset of milk production and gradual cessation to be a very important and powerful part of the grief process. There are families who choose to lactate and donate milk as part of an ongoing legacy for their deceased babies, so the decision to suppress lactation should not be assumed.<sup>1</sup>

Serious maternal or infant illness may require urgent weaning and/or lactation suppression, as may adoption or a past or present history of breastfeeding complications. Personal choice is also a valid reason to suppress lactation for families who have weighed the risks and benefits of breastfeeding for both the breastfeeding parent and the infant and have decided that formula feeding or donor milk is a more suitable alternative.

### When should lactation suppression take place?

Management of lactation suppression varies slightly depending on whether it occurs immediately postpartum or once milk supply has been established.<sup>1</sup>

In some lactating caregivers, colostrum will be produced as early as 16 weeks' gestation, so suppression should be discussed with anyone delivering from this gestation. Regardless of whether breastfeeding is initiated, milk production will usually commence around day 3–4 postpartum (possibly earlier if they have lactated before) as lactation at this stage is under hormonal control. For some women, this can result in engorgement, discomfort and leakage, which, depending on the circumstances surrounding the delivery, can be very distressing for some parents, yet comforting for others. If the

breasts are not stimulated, the supply will gradually reduce and cease over a few weeks. If parents are not wanting to commence or establish lactation, suppression should take place as early as possible, ideally within 24 hours of delivery.

If lactation has already commenced and established, a more gradual approach over a week or two is usually preferable to prevent complications such as blocked ducts, mastitis and breast abscess. Onset of milk production after the baby has been delivered may happen earlier if the parent has lactated before; however, this usually doesn't occur prior to 24 hours postpartum and won't alter the efficacy of lactation suppression in the immediate postpartum period.

### How to suppress lactation

Regardless of the timing of lactation suppression, some basic non-pharmacological interventions can significantly reduce both the onset of milk production and the associated discomfort.

These measures include wearing firm, well fitting breast support, avoiding heat (unless needing to manage engorgement), using cold packs to both reduce blood flow and treat the inflammatory changes associated with lactation and providing regular simple analgesia such as ibuprofen and/or paracetamol. Breastfeeding parents should be advised to avoid stimulating the breasts as much as possible, as the simple act of checking to see if milk is still being produced can be enough to promote milk production. If the parent finds themselves to be painfully engorged, it may be necessary to remove a small amount of milk to relieve discomfort. In this instance, some gentle breast massage in a warm shower may be all that is needed to remove enough milk to be comfortable. It is important that the breasts aren't drained completely, as this will stimulate further milk production.<sup>2</sup>

When reducing an already established supply, the recommendation is to gradually reduce the number of breastfeeds (or expressions) per day, starting with the least most productive feed. Every 3–4 days, if the breasts are feeling comfortable, a further feed would be ceased and replaced with a breastmilk substitute. If exclusively expressing, some will choose to just increase the time between pumping sessions every



few days until down to 1–2 pumps per day, by which point the supply is likely to be low enough to be able to comfortably stop removing milk.<sup>2</sup>

If there is a need to expedite lactation suppression, medications such as cabergoline, oestrogen, and pseudoephedrine can be used with caution.

Cabergoline suppresses prolactin, the hormone responsible for milk production. If being used immediately postpartum prior to lactation being established, a single dose of 1mg will suffice. If lactation has been established, cabergoline 250mcg BD for two days is required. Common side effects associated with cabergoline include dizziness, headaches, nausea and hypotension.<sup>2,3</sup>

The combined oral contraceptive pill is known to reduce breastmilk supply in established lactation; however, the risk of thromboembolism needs to be carefully considered in the immediate postpartum period.<sup>4</sup>

There is also evidence that pseudoephedrine significantly reduces supply in established lactation. The exact mechanism is unknown; however, it is thought to be related to the dopaminergic actions of the drug in the pituitary, causing alterations in prolactin levels. A single dose of 60mg has been shown to reduce milk production by up to 24%, but it appears to be safe to use the usual nasal decongestant dose of 60mg QID for 2–5 days in people with a more generous supply.<sup>5</sup>

While historical treatments for lactation suppression such as applying jasmine flowers to the breasts and drinking sage tea are still in use today, a Cochrane review in 2012 found that there is very limited data on the efficacy of these treatments.<sup>4</sup>

### How long will lactation suppression take?

For most people, milk production will not be noticeable within a few weeks, but for some it can take many months to completely suppress lactation. Once lactation has been established, the process is likely to take much longer, and some will still be producing very small amounts of milk for up to a year, though this will only be noticeable if actively looked for.

It is important to remember that regardless of the reason for lactation suppression, the timing of the intervention or the method used, for the parent, there is likely to be a huge psychological burden associated with the decision, even if it's a decision they are very confident in. As such, compassion, patience and support should be the underlying foundation on which to base any one of these managements.

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## Case reports

## Rare uterine events



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As clinicians, it is important to consider rare diagnoses when managing a busy obstetric unit. This article describes two such cases of rare uterine complications that occurred in a New Zealand tertiary obstetric unit: a uterine torsion and a uterine rupture. Uterine torsion is a rare event and is life threatening to both mother and baby if rotation is greater than 45 degrees. There are a few hundred cases reported in the literature since it was first described in 1863.<sup>1</sup> The diagnosis can be difficult, due to vague symptoms, but prompt recognition and surgical intervention can mitigate maternal and perinatal morbidity and mortality. Uterine rupture is another rare and pathological event for both mother and fetus. This can occur prior to or during labour, and in the presence of a predisposing risk factor offers an opportunity to try to minimise risk antenatally.<sup>2</sup> It is our hope that ongoing publications of rare cases will help improve clinician knowledge, recognition and management of rare obstetric events.

#### Case one: uterine torsion

A 39-year-old woman presented for an induction at 37 weeks for mild preeclampsia that was diagnosed at 36 weeks, along with a transverse lie. Her obstetric history consisted of G6P5 with all previous vaginal deliveries. On the day of induction, the lie was noted to be unstable and consent for external cephalic version (ECV) prior to induction was gained. The ECV was performed that afternoon with terbutaline tocolysis and a Cooks balloon catheter was required. The woman began contracting at 0500 the next morning, the Cooks catheter was removed and a small amount of dark blood noted. At 0630 the registrar was called to see the woman with increasing pain. She was noted to be 1cm with a transverse lie, normal observations and normal CTG. The woman was booked for category 2 caesarean section and terbutaline was given. The woman was reviewed by registrar and

consultant again at 0730 on returning from theatre with another patient and were happy to proceed with caesarean. Twenty minutes later, the registrar was called back to her room for a bradycardia. A crash caesarean section was requested, and the oncoming day registrar was instructed to perform this. General anaesthesia was given, and on opening the peritoneal cavity, a couvelaire uterus was noted with adnexal structures running diagonally over what appeared to be a twisted lower uterus. A transverse incision was made high on the posterior aspect of the lower uterine segment and the fetus was delivered via breech extraction. The placenta was delivered and the uterus was exteriorised, detorted 180 degrees and the posterior hysterotomy repaired with two-layer closure. Syntocinon bolus, syntocinon infusion and two doses of carboprost were required for tone and the total blood loss was 3100 ml. The woman recovered well postoperatively and was debriefed with her family; however, the baby was noted to have poor apgars and arterial cord gas pH of 6.76 and lactate of 17 due to the abruption. The baby required 72 hours of cooling for hypoxic ischemic encephalopathy (stage 2). During admission, the baby's neurological exams remained normal and they had a normal on day 6 MRI brain. At the child's 12-month clinic follow up there was normal developmental progress and growth.

The uterus can tort in both the gravid and non-gravid states and is considered pathological if beyond 45 degrees.<sup>1</sup> The most common presenting symptom is pain with other features including malpresentation, fetal distress, vaginal bleeding and shock, and as in our case, placental abruption can be noted in 4% of cases.<sup>1,3</sup> It can occur in acute, subacute, chronic and intermittent states. In gravid patients, if time allows, a change in placental location on ultrasound can be helpful in diagnosis.<sup>1</sup> It can occur in all trimesters of pregnancy and postpartum with the most common being the third trimester at 49%.<sup>3</sup> The three most recent reviews of the cases include a 1992 report (212 cases),<sup>3</sup> 2006 report (18 additional cases)<sup>4</sup> and, most recently, a 2020 review that added another 41 cases.<sup>1</sup> Predisposing factors include a uterine malformation, loosely suspended uterus, abdominal wall laxity, pelvic adhesions or masses including fibroids, although at times there is no pelvic abnormality identified.<sup>1</sup>

Cases associated with ECV and ongoing additional attempts at ECV with torsion-induced placental hypoperfusion and fetal distress have been described in the literature.<sup>1</sup> Intraoperative findings include distorted lower segment, varicosities, ovaries in anterior position in relation to broad ligament and the round or infundibulopelvic ligament crossing the uterus anteriorly, and often torsion is in left to right direction.<sup>1,3</sup> Posterior hysterotomy (intentional and unintentional) for delivery has been shown in 61% and a transverse incision shows an advantage of less blood loss, time and risk of subsequent rupture.<sup>1</sup> For our patient, detorsion prior to hysterotomy was not possible and careful evaluation of safe entry to



Figure 1. Fundal uterine rupture through myomectomy scar.

the uterus was performed in a timely manner. Contraception was arranged for the woman on discharge, but the subsequent rupture risk of the posterior hysterotomy is unknown and therefore advised repeat caesarean section for any future pregnancies.<sup>4</sup> The outcome in this case was good for both mother and baby and the literature shows a decrease in both maternal and perinatal morbidity to 2.4% and 18–22% respectively since 1956.<sup>1,3,4</sup>

#### Case two: uterine rupture

A 35-year-old woman presented at 26 weeks to the obstetric assessment unit with sudden onset of lower back and suprapubic pain with associated vomiting. Her medical and obstetric history included a previous laparoscopic fundal myomectomy and G2P1 with a previous caesarean section three years prior for obstructed labour at 41 weeks with an incidental finding of uterine rupture at the fundus. She had been seen in the antenatal clinic with a recommendation to have an elective caesarean section at 38 weeks to avoid labour. On arrival, her blood pressure was 80/50 with a heart rate of 80. The uterus was irritable and tender to palpation, the cervix was long and closed and a bedside scan showed normal liquor volume, fetal heart rate and a breech presentation. Investigations including an urgent ultrasound were requested and the pain settled with analgesia and intravenous fluids. The ultrasound later that afternoon showed simple fluid around the right ovary and pelvis, an anterior and clear placenta and fetal weight of 940g.

The working diagnosis at this point was appendicitis versus uterine rupture and after consultant discussion, they agreed to review the patient and requested antenatal steroids to be given and a surgical review. While awaiting consultant review, a tonic contraction and bradycardia was noted by the midwife. A crash caesarean section was performed and on opening the peritoneal cavity, a 1600ml haemoperitoneum was noted with the placenta and fetus en caul in the abdominal cavity. The uterus on inspection had a defect in the fundus (see Figure 1) and this was repaired in three layers and 2 units

of red cells transfused. The woman was debriefed postoperatively and had an uncomplicated recovery. The baby had a prolonged hospital course with need for ongoing follow up for chronic lung disease but was developmentally normal and was discharged from the paediatric service at two years of age.

Uterine rupture is an obstetric emergency and often presents with an abnormal CTG, abdominal pain, loss of uterine contractions, recession of fetal parts and shock.<sup>2</sup> Previous uterine surgery such as myomectomy or caesarean section are predisposing risk factors for uterine rupture. The incidence of rupture following myomectomy is difficult to establish in the literature, although a 2016 systematic review of 1034 pregnancies after myomectomy suggested a prelabour incidence of 1.52% and intrapartum of 0.47% which is similar to incidence for those with a prior caesarean section.<sup>2</sup> There appeared to be no significant difference in rupture risk with fibroid location, surgical approach and technique, though the case numbers are small.<sup>2</sup> Rupture has been shown to occur at any gestation, but most commonly in the second or early third trimester, such as our case.<sup>2</sup> Repair of defects, obtaining haemostasis and avoidance of hysterectomy is the goal in treatment and optimal technique has not been well established due to rarity, variability in location and damage extent.<sup>5,6</sup> The maternal mortality rate is 1/500 uterine ruptures with a perinatal mortality rate associated with rupture of 5–26%.<sup>5</sup> Recurrent rupture data is also based on small case numbers, with a risk of 0–33%. Longitudinal ruptures show increased risk for recurrence.<sup>6</sup> Some studies suggest that a trial of labour could be a safe alternative, preferentially to those with intramural or pedunculated myomectomy as the rate of rupture has been shown to be similar to prior caesarean; however, this is controversial and based on small case numbers.<sup>2</sup> The American College of Obstetrics and Gynaecology recommends an elective caesarean section for those with previous myomectomy at 37–38+6 weeks and 36+0–37+0 weeks for a previous rupture.<sup>7</sup>

Both of these rare uterine events can have significant impacts for both maternal and fetal health. It is important to be wary of a patient with a previous uterine rupture, even at early gestations in subsequent pregnancies, and have a clear plan for delivery timing. Awareness of uterine torsion as a condition and recognition of intraoperative findings to allow safe hysterotomy and delivery is also valuable for obstetric clinicians. Ongoing publication of case studies aims to improve recognition of challenging diagnoses and outcomes for future patients that require swift management.

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# Angiomatosis of the uterus and cervix

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Angiomatosis is a vascular malformation characterised by a diffuse network of variably sized blood vessels involving multiple tissue planes. It is known to affect skin, deep soft tissue, bone and are often clinically extensive. Angiomatosis of the uterus and cervix is extremely rare, with a paucity of literature describing this phenomenon. To our knowledge, only one other case report has described this condition, which was in a 27-year-old female who presented with intractable menorrhagia unresponsive to all conservative forms of treatment.<sup>1</sup> We present an unexpected case of angiomatosis of the uterus and cervix in a young female.

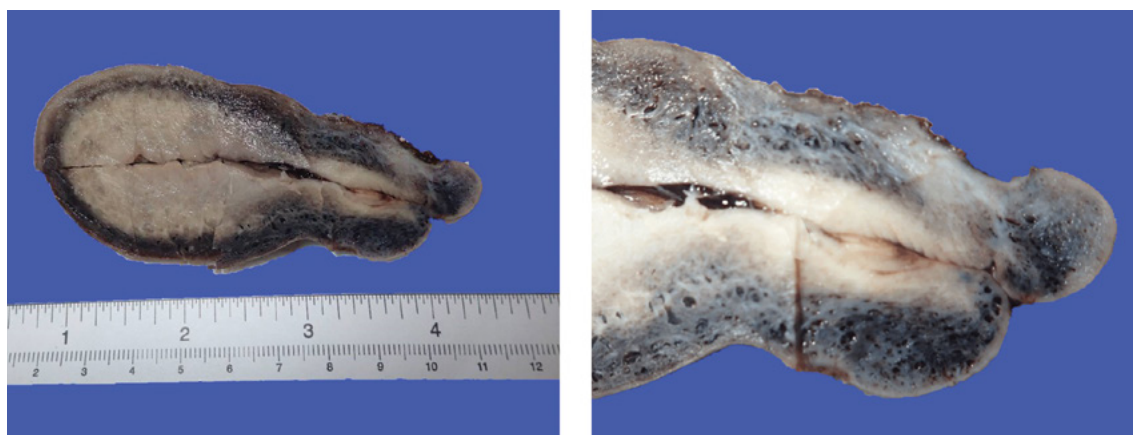
A 29-year-old woman presented with a long-standing history of dysmenorrhea and menorrhagia resulting in iron deficiency. She had five uncomplicated vaginal deliveries with no other relevant medical history. A transabdominal and transvaginal ultrasound demonstrated a normal endometrial thickness of 4.4mm, no focal lesions and a homogenous

myometrium. The initial clinical impression for her symptoms was adenomyosis. A trial of a hormone-releasing intrauterine device was poorly tolerated as it worsened her symptoms. She declined other conservative measures and opted for an elective total hysterectomy for definitive treatment.

Macroscopically, the uterus appeared symmetrical and mildly enlarged with a dusky appearance. Sectioning showed a band-like dark purple discoloration of the outer one third of the cervix and myometrium associated with prominent blood vessels (Figure 1). Histological examination featured angiomatosis, characterised by a diffuse permeation of the outer half of the myometrium and cervix by a mixture of thick- and thin-walled vascular channels of varying sizes, lined by flattened, benign endothelial cells (Figure 2). The endometrium showed early secretory changes with no other abnormalities to account for abnormal bleeding. The fallopian tubes, which were also removed, did not demonstrate angiomatous lesions. She recovered well from the surgery.

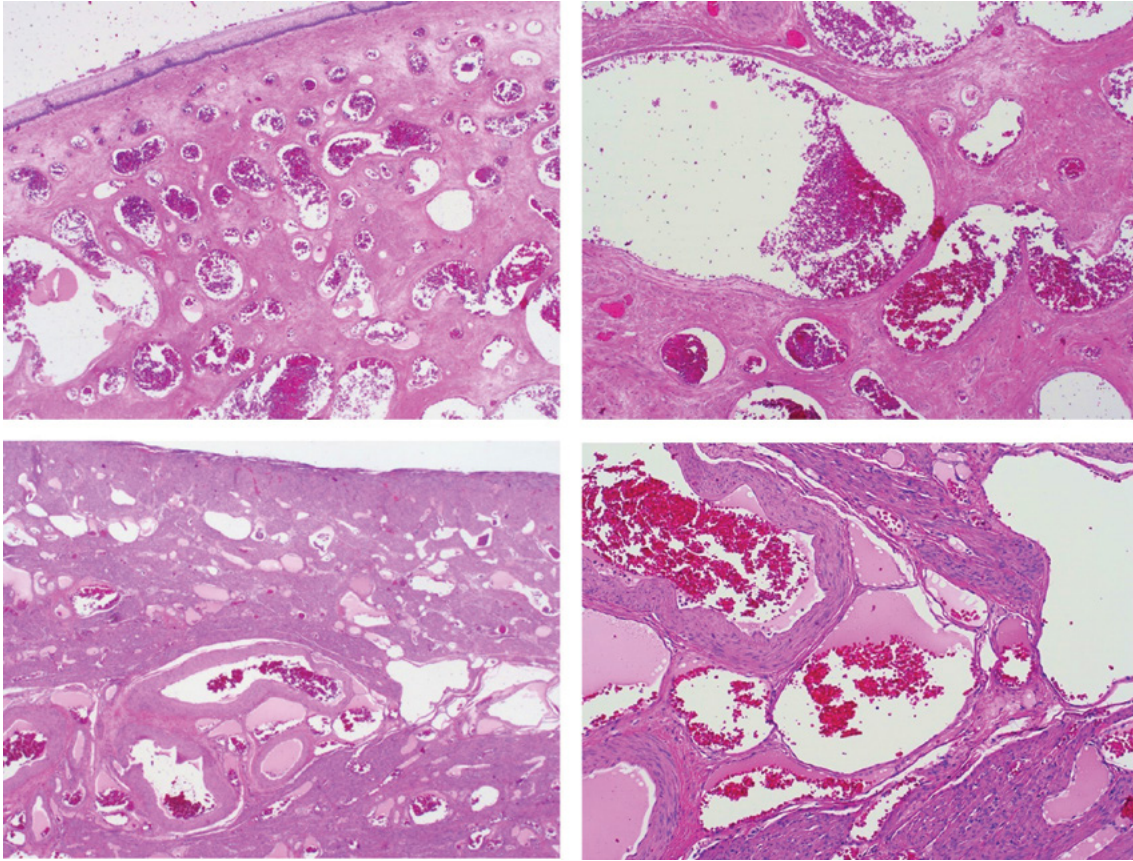
Angiomatosis, which is regarded as a diffuse form of hemangioma, is not included in the standardised nomenclature as a disease of the uterus and cervix. As a result, this condition is likely to be underdiagnosed and it continues to represent a pathological curiosity. Moreover, clinical examination and routine investigations for menorrhagia, including hysteroscopy, endometrial curettage and ultrasonography, are likely to be unhelpful in this instance. Therefore, definitive diagnosis of angiomatosis relies heavily on histopathology.

Angiomatosis in the usual deep soft tissue sites can cause pain and persistent swelling that is worsened with strenuous exercise. Moreover, conventional angiomatosis can be associated with certain



**Figure 1. (Right)** The uterus shows a continuous peripheral rim of dark purple discoloration. **(Left)** The area of discoloration appears to be representing numerous congested blood vessels.





**Figure 2.** (Top right and left, H&E) Uterine cervix show numerous ectatic vascular channels lined by benign endothelial cells. (Bottom right and left, H&E) Uterine corpus similarly show vascular channels of varying sizes extensively involving the myometrium.

syndromes such as Klippel Trenaunay syndrome, Sneddon's syndrome or Gorham disease.<sup>2</sup> However, the clinical presentation and significance of this histological finding in the uterus and cervix is largely unknown. In a similar case report of a 27-year-old with angiomas of the uterus, cervix and fallopian tubes by C Pontre et al,<sup>4</sup> the patient presented with intractable heavy menstrual bleeding that is unresponsive to all conventional and conservative forms of treatment. On a slightly different note, within the same spectrum of vascular lesions, a retrospective study conducted in Taiwan on uterine haemangiomas, it was found that one of the most common presentations is menorrhagia.<sup>3</sup> Likewise, heavy, painful menstrual bleeding represents the chief complaint of our index case. Therefore, it appears that angiomas of the uterus and cervix represents a feasible explanation for heavy menstrual bleeding in young females with no other identifiable cause. This is especially true in patients who are not responding to standard treatments.

As histopathological examination is the key to definitive diagnosis of angiomas of the uterus and cervix, maintaining a broad differential diagnosis and having a good understanding of various benign vascular lesions of the uterus and cervix is of paramount importance. More research into understanding the pathogenesis of this condition in the uterus and cervix will be the next step going forward. This should be followed by the development of diagnostic criteria and management guidelines to prevent undertreatment and/or overtreatment.

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## Global Health

# RANZCOG Global Health Experience Map

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RANZCOG launched the online Global Health Experience Map in early 2021. This member-only accessible resource can be viewed at: [ranzco.edu.au/womens-health/global/experience-map](https://ranzco.edu.au/womens-health/global/experience-map)

Detailing the volunteering and/or work experiences of College members and trainees in obstetrics and gynaecology in low- to middle-income countries, the map highlights their contribution to global women's health. Information currently presented on the map

was collected via an online form and continues to be updated and new experiences collected to maintain the map's currency. Members and trainees who have yet to tell the College about their global health experiences can do so here: [www.cognitoforms.com/RANZCOG/myglobalhealthexperience](https://www.cognitoforms.com/RANZCOG/myglobalhealthexperience)

The Global Health Experience Map also serves as a useful tool for College members and trainees with an interest in contributing to global women's health and who may wish to learn about available opportunities and pathways, and even connect with those members and trainees whose experiences are presented on the map to learn more. Information presented on the map is personalised, listing country, work undertaken, recency (past or current), timeframe (short- or long-term), and arrangements, including organisations through which the work was arranged and/or funded. Several are listed, including Médecins Sans Frontières (MSF) Australia.

## Organisation showcase: MSF Australia

MSF is committed to reducing death and suffering among people who have been affected by an acute crisis and/or excluded from healthcare, often in unstable or remote regions. Pregnant and labouring women are a priority due to the potentially serious complications they face in such situations. In 2020, MSF staff assisted 306,800 births, including by caesarean section. MSF is also increasingly caring for women pre-cancer or with cancer, including cervical cancer.

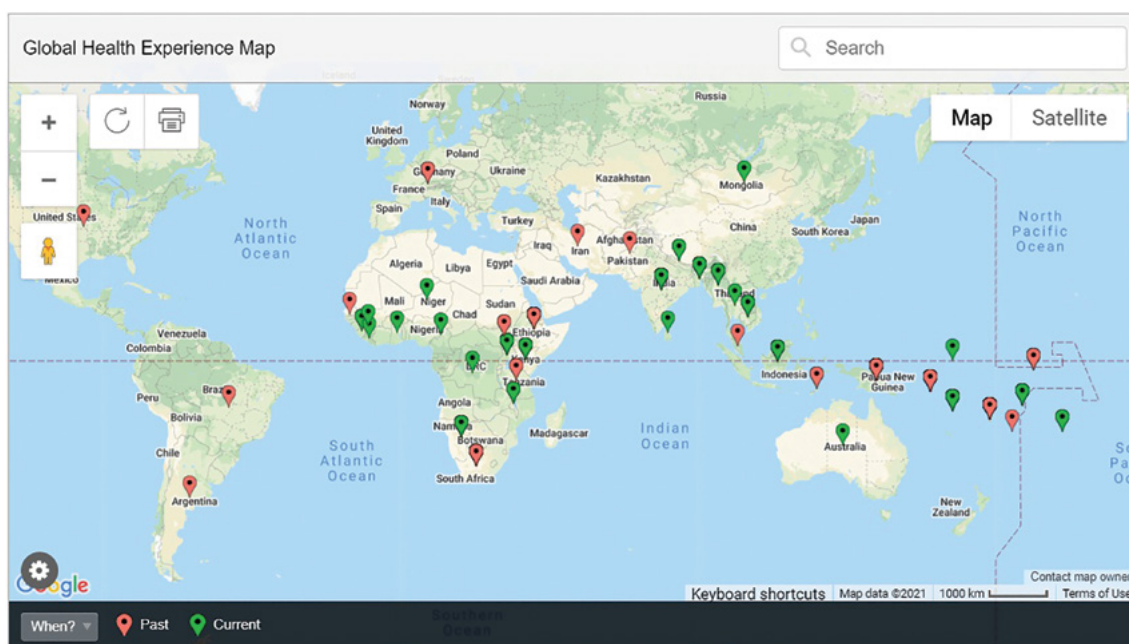


Figure 1. Global Health Experience Map screenshot.



Successful FRANZCOG applicants are usually placed in a maternity hospital in a country such as Yemen, Afghanistan, Pakistan or South Sudan, either fully operated by MSF or in partnership with the Ministry of Health. They join a mostly local medical team delivering high-quality care, supported by standardised MSF protocols, equipment and medicines. The specific challenges vary but the care is always adapted to the setting, so that compared to a high-income, metropolitan hospital, the relatively small medical team will be doing more, with less.

In South Sudan, for example, MSF runs projects to assist internally displaced people and people affected by ongoing violence. Hospitals may be established in tents and basic buildings in camps and small towns. MSF provides emergency care for women and children and strives to create clean, safe birthing spaces to avoid the transmission of diseases, such as tetanus to the newborns. Caesarean sections are usually only indicated for the purpose of saving a mother's life, or to avoid long-term gynaecological complications such as fistula formation. Women also seek care having been victims of sexual violence, sometimes the targets of rape as a strategy of war.

Working with MSF as an obstetrician or midwife in such a setting is extremely challenging, as resources

are limited and the conditions are very basic. Yet the benefit for individual patients is very clear, due to the lack of alternative healthcare for women and girls, and the geographic isolation of the towns.

In MSF-run maternity hospitals such as in Pakistan, MSF aims to provide care for the women within a region who have difficulty accessing other healthcare services due to cost or cultural barriers. In a well-established project such as Peshawar Women's Hospital, MSF can also dedicate resources for ongoing improvements in care. These types of projects present a different range of tasks for midwives and obstetricians alike, who need to focus on managing a team of staff employed by MSF and providing technical support as well as training.

Although modest, occasionally there are opportunities for advanced trainees to undertake some training with MSF. Dr Andrea Atkinson started working for MSF as a general doctor and has recently completed a placement in Peshawar, working alongside local staff including gynaecologists, as part of her advanced training.

It is through Andrea's eyes that we discover some of the work and challenges on assignment with MSF, in the accompanying article.

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# Obstetric practice with MSF in Pakistan



**Dr Andrea Atkinson**  
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Peshawar Women's Hospital (PWH), a maternity hospital that was opened by Médecins Sans Frontières (MSF) in northern Pakistan in 2011, has celebrated its tenth anniversary this year. Its location in Peshawar city provides a neutral access point to healthcare for the vulnerable population of women that it assists: women from the ex-FATA (Federally Administered Tribal Areas) region along the Pakistan-Afghanistan border; Afghan refugees; and women from the surrounding rural areas.

These patients are over-represented in maternal and neonatal morbidity and mortality in the region,

with recent estimates of maternal mortality in rural regions 25% higher than urban areas.<sup>1</sup> Even at national level, Pakistan's rates are high by world standards: neonatal mortality was estimated at 41 deaths per 1000 live births in 2019,<sup>2</sup> and maternal mortality at 140 per 100,000 in 2017.<sup>3</sup>

## Complications of induced labour

Over the years, PWH has understandably grown, and now conducts 550–700 deliveries per month. Patients receive free care and remuneration for the cost of travel – just one of the obstacles they face to receive safe care in labour. Due to some of the distances and the capacity of other facilities at which a patient may begin her labour, it is not unusual to receive patients who are near collapse on their arrival to PWH. In addition, 'oxytocin abuse' is rife in Pakistan and is a bewildering concept for practitioners coming from other countries. MSF has previously focused strongly on this in its program in remote Timergara, and published on the topic in 2016.<sup>4</sup>

The drivers for the misuse of oxytocin are complex, with cultural, familial and monetary incentives at play. This was illustrated by the case of Haleema.\* Haleema had attended a clinic in her hometown many hours away from PWH and had been provided with several injections of oxytocin (standard 10-unit ampoules administered intramuscularly) to expedite the delivery of the next addition to her family, despite having had a previous caesarean section.



Shareef Noreen, an Afghan refugee, rests after delivery of her first baby at Peshawar Women's Hospital.  
© Zahra Shoukat/MSF.





An example of MSF health promotion graphics on oxytocin misuse. ©MSF

It is unclear at which point the patient and her family realised something was wrong and decided to drive to PWH, but on arrival, Haleema was gasping, pale and hypotensive, with a ruptured uterus and approximately three litres of blood intra-abdominally. Given the extent and location of the rupture, there was no doubt that a hysterectomy was necessary and unavoidable.

The decision to perform a hysterectomy in a context like this is extremely challenging, given that the value of a woman is intrinsically linked to her ability to reproduce. Women who come to PWH do not hold identity cards themselves, but provide their husband's card and name for their registration. Although legally women are allowed to provide consent, this is not culturally accepted, and in PWH a husband's permission is obtained as far as possible for any surgical procedure, or administration of contraception. On this occasion, we were fortunate that Haleema's husband was understanding of the situation and extremely grateful to have his wife's life saved, as he had lost a close relative during childbirth.

#### Auditing perinatal asphyxia

MSF continues to search for new ways to educate and advocate on the issue of oxytocin abuse. However, at PWH we also wanted to be able to

look internally at our own practice and optimise outcomes for the patients whose deliveries we care for and manage. Specifically, the hospital team has increasingly focused on the area of perinatal asphyxia (or birth asphyxia). Perinatal asphyxia is consistently found to be among the leading causes of early neonatal mortality, after preterm birth, in Pakistan and globally.<sup>5</sup> In addition, intrapartum stillbirth due to intrauterine hypoxaemia often goes unrecorded and under-reported but is on a continuum that results in an estimated 1 million stillbirths worldwide,<sup>6</sup> and presents an avoidable cause of perinatal mortality through improved obstetric practice.

Previously, the MSF team at the now-closed Dasht-e-Barchi maternity hospital in Afghanistan had used Robson grouping to look at associations with perinatal asphyxia.<sup>7</sup> Concerned by the high rates of perinatal asphyxia that persisted in our neonatal birth unit, the team at PWH decided to do the same. A series of audits were undertaken at PWH and, just as in Dasht-e-Barchi, breech vaginal deliveries showed higher rates of perinatal asphyxia and perinatal mortality.

My first objective during my six-month position at PWH was to find a way to adapt a protocol on



Dr Andrea Atkinson undertakes a caesarean section with Dr Kamal Akbar Afridi, anaesthetist, and Shabana Isaacs, operating theatre nurse, in Peshawar Women's Hospital. ©MSF.

management of breech deliveries into the basic structure and capacity of the project, in line with treatment in other local hospitals. The project had caesarean sections rates of around 7–10.5%, while providing care as a referral centre for complicated and what were often categorised as 'mishandled' deliveries, as demonstrated in Haleema's story above. Given the geography and poor health literacy of our catchment population, any action that potentially increased the caesarean section rate needed to be considered very carefully to ameliorate the risk of rupture for future deliveries. The decision to perform a caesarean section takes on additional layers of complexity when a patient may not have timely access to healthcare services in the future, may need to deliver in a facility without adequate resources, or may receive excessive and unregulated doses of oxytocin or misoprostol.

### Implementing a new protocol

We decided that a small increase in the caesarean rate would be acceptable if it helped us reduce the perinatal asphyxia caseload. Coming up with this protocol was made possible by the excellent collaboration of advisors based all over the world contributing their experience and opinions. Importantly, the advisors were in full support of the decisions and approach of the field team in trying to create a protocol that allowed patients a more active role in the decision about mode of delivery.

At PWH what we ultimately agreed upon, and implemented, was a protocol that allowed: the offer of a caesarean section when a woman had multiple risk factors, in addition to breech, that are associated with poorer neonatal outcomes; increased surveillance with more frequent intermittent

auscultation of fetal heart rate; consultant presence at delivery; and pre-delivery planning including ultrasound assessment of fetal estimated weight.

Monthly audit of the outcomes of breech deliveries is planned, and has been made possible via the hospital's new data collecting system. It is early days under the new protocol, but in the first two months the caesarean section rate remained stable, at 11% and 10.5% respectively, with a pronounced reduction in neonates admitted with perinatal asphyxia following delivery (caesarean section or vaginal) with breech presentation.

This was a new and interesting challenge for me on my third assignment with MSF – a journey that has paralleled my journey to become an O&G. There is so much scope for making a difference through work in MSF's field projects, not only to individual patients, but also to the skills and knowledge of fellow healthcare staff, and the organisation as a whole. I would highly recommend any trainees or Fellows to find out more about working with MSF. For this work there will never be a perfect time, but the experience will be worth every sacrifice to make it a reality.

\*Patient name and some details have been changed to preserve confidentiality.

### References

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2. UNICEF Data Warehouse. Available from: [data.unicef.org/resources/data\\_explorer/unicef\\_f/?ag=UNICEF&df=GLOBAL\\_DATAFLOW&ver=1.0&dq=PAK.CME\\_MRM0.&startPeriod=1970&endPeriod=2021](https://data.unicef.org/resources/data_explorer/unicef_f/?ag=UNICEF&df=GLOBAL_DATAFLOW&ver=1.0&dq=PAK.CME_MRM0.&startPeriod=1970&endPeriod=2021).

Full references available online.

# Obituaries

## Dr Gregory John Kesby 1963–2021

It is with much sadness that we record the death of Dr Greg Kesby on 25th October 2021 at the age of 58.

Greg graduated with honours in both science in 1985 and medicine in 1988 from the University of New South Wales. He subsequently completed a PhD in teratology, studying the effect of drugs on neural tube development where he commenced his O&G training at Addenbrooke's & Rosie Maternity Hospitals, Cambridge, from 1992 to 1993. He then returned to Australia and commenced as a Registrar at King George V Hospital in Sydney. He developed an interest in high-risk obstetrics and was appointed as a Fellow in Maternal-Fetal Medicine 1996 and a Staff Specialist (Maternal-Fetal Medicine) in 1997. He was appointed Associate Professor in Obstetrics and Gynaecology at The Chinese University of Hong Kong from 1998 until 1999, then returned to Sydney and became a partner at Sydney Ultrasound for Women and was appointed a Senior Visiting Medical Officer, Department of High-Risk Obstetrics at Royal Prince Alfred & King George V Hospitals in 2000. He was elevated to Head of Department in 2005, a position that he held until 2008 and remained an active member of the visiting staff until his passing.

Greg was awarded the Diploma of Diagnostic Ultrasound in 1997 and obtained RANZCOG Fellowship in 1998 and was Certified in Maternal-Fetal Medicine in 2000. In 2006, he was appointed to the Board of Examiners, Membership Examinations at RANZCOG and subsequently served several terms on College Council and was a past Chair of the Professionalism and Ethics Committee.

From the early years of his consultant practice, Greg voluntarily devoted great energy to ethics, hospital and practice standards and advancing the regulation of medical practice in a quality framework through his involvement in the NSW Medical Board where he was appointed to the Conduct Committee in 2002 and ultimately assumed the Chair in 2011. He was also passionate about sharing his knowledge of the

regulatory environment in healthcare and went to great lengths to ensure the NSW Medical Council's programs to assist doctors and students were accessible and well understood.

He was a scholar, won numerous awards and was a fitting recipient of several travel fellowships that helped ensure Australian practice in ultrasound, high risk obstetrics and fetal medicine in both the public and private sectors could be maintained at world-class standard.

Greg's main clinical interests were in the areas of intrauterine fetal therapy and the management of complex pregnancies, particularly multiple pregnancies, and in these areas he collected a vast cohort of patients in both the public and private sectors who valued his 'hands on' management above all else. He was particularly gifted in his ability to counsel patients in the most dire of circumstances and guide them through their traumas with his clinical expertise and compassion.

He was also an excellent teacher who guided both clinicians as well as sonographers through both specialist and subspecialty training with his intellect, enthusiasm for his discipline and engaging personality, as well as a wicked sense of humour, making it a pleasure to work with and learn from him.

As a man he was highly intelligent but modest, hilarious but appropriately serious when the situation called for gravitas. He loved food, wine and travel which was sadly denied him in this past year due to illness and Covid.

He was greatly loved by family, friends, colleagues, and patients, all of whom will miss the presence of this completely unique person.

He will be particularly missed by the staff at Sydney Ultrasound for Medicine and the Fetal Medicine Department at Royal Prince Alfred Hospital as well as his daughter Hanna and partner Vanessa.

Vale Greg.

## Dr Thomas Mackenzie Fiddes 1939–2021

Tom sadly died on 27 September 2021, following a short illness with pancreatic cancer. He graduated in medicine from the University of Otago in 1966 and spent his early postgraduate life in Christchurch, where he completed his Diploma of Obstetrics. He and his wife, Chris, had planned to travel to Canada to start his life as a GP but, on an overland trip from India to England, Chris discovered she was pregnant with their second child. With the need to stay in the UK for Chris to give birth, Tom decided to change direction and specialise in O&G. His first position was at the George Eliot Hospital in Nuneaton before completing his membership studies at the Walsgrave Hospital in Coventry. At the Walsgrave hospital, he had an early introduction to an ultrasound machine

and, when he returned to New Zealand in 1974 as a Senior Lecturer with the University of Otago and Dunedin Hospital, he introduced this amazing new technology to NZ obstetric practice. Tom performed all the obstetric ultrasound examinations before radiology eventually took it over. He reflected 'from black and white still shots painted and displayed on an oscilloscope, where we were lucky to see the placenta, we progressed through to fine anatomical detail and physiological measurements allowing credible comment on fetal wellbeing'.

He was a consummate obstetrician and excellent surgeon, and the hospital awarded him a clinical excellence award. He embraced the early days of laparoscopy, and one of his early research papers was on the use of intraperitoneal local anaesthesia as pain



prophylaxis for sterilisation, this being incorporated into the RCOG Best Practice Guidelines.

He was interested in the physical surrounds of birth and headed up a group that set up the first birthing unit in a public hospital in NZ. When the Hospital Board announced its intention to close the Queen Mary site, he vigorously led a public response that attracted many hundreds of people marching down George St. Alas this fell on deaf ears, and Tom's beloved birthing unit was no more.

He had a passion for teaching at all levels, but he will be remembered for developing the first distance teaching program for the Diploma of Obstetrics. This ultimately became a collaborative exercise between all three O&G Departments at the University of Otago [Wellington, Christchurch and Dunedin] and from 2000, the University of Auckland. The current teaching programs in the Postgraduate

Diploma in Obstetrics and Medical Gynaecology and the Postgraduate Certificate in Women's Health have been modelled on Tom's original work and are his lasting legacy. At the College, he was a member of the RANZCOG Council and was involved in the introduction of continuing medical education for the Fellows.

After 33 years with the University of Otago, Tom's natural talent for developing teaching programs took him to the Fiji School of Medicine, where he spent five years as a team leader in the development of their postgraduate training project. In 2003, he joined the Grey Base Hospital in Greymouth as Consultant and Intern Supervisor and then as Academic Director of the Rural Learning Centre, until retiring in 2015.

He married Chris in 1965 and is survived by her, two children (Grant and Kirsty) and two granddaughters.

### Dr Victor Thompson White 1925–2021

Victor White died peacefully on 1 August this year at the age of 96. For those in the medical community who knew him, he would be considered a West Australian legend. He was born in Western Australia, and attended Nedlands Primary, Claremont Central, and Perth Modern Schools. After his first year at the University of Western Australia, he completed his medical degree with honours at the University of Melbourne, where he resided at Ormond College. After an internship in Melbourne, he took up resident positions at Fremantle and King Edward Memorial Hospitals (KEMH), before travelling to the UK to undertake specialist training. He returned to Perth in 1954 as one of its first specialists in Obstetrics and Gynaecology, thus commencing a long and distinguished career dedicated to the practice, promotion, and development of O&G in Western Australia.

Vic's name will always be associated with KEMH, where he was an honorary or visiting consultant for 38 years. He participated in or chaired many hospital committees and services including the Clinical Association and Hospital Board. His pivotal role in establishing and supporting the Oncology service at King Edward Memorial is widely recognised. He was a tutor and examiner for The University of Western Australia, a member of the State Council of the AMA, and undertook many regional and national College roles. He became a foundation Fellow of the Royal Australian College of Obstetrics and Gynaecology and a member of its first council. He served on or advised many other state committees and spent 16 years in the Australian Army Citizens Military Force, attaining the rank of major. In 2008, he was awarded Membership of the Order of Australia (AM), 'for service to medicine in the fields of obstetrics and gynaecology through clinical, teaching and administrative roles and contributions to a range of professional organisations'. Vic will be remembered fondly and gratefully by many thousands of patients, and many hundreds of medical students, midwives, residents, registrars, general practitioners, and co-consultants who he taught or mentored. He was renowned not only for his clinical

skills but also for the respect, courtesy, and kindness that he showed to all.

Vic's sporting achievements are less well known, yet he won the WA state schoolboys' hurdles in 1942, setting a record he held for nine years. During the wartime years he played for Claremont in the underage West Australian Football League. At Ormond he earned a Hockey 'blue' and was selected in the combined Australian Universities Hockey team. With his flaming red hair and his name 'White', he was often affectionately known as 'Red, White, and Blue'. He continued to play for the University Associates Hockey team in Perth.

Vic was loved by virtually all who knew him. He is much mourned by his wife Rhoda – with whom he had a long, loving, and successful marriage for over 67 years – by his children Phillip, Jane, Michael and Stephen, his grandchildren Tristan, Emma, Sophie, Cait, Cam, Thomas and Sarah, and his step grandchildren James, Mathew and Jessica. He is mourned also by me, who knew him as a teacher and father-in law, and his three daughters-in law, Carol, Kim, and Maureen, along with his great grandchildren, his extended family, and wide circle of friends. He instilled in his family his love of life and knowledge, and supported and encouraged them in all their endeavours, leaving a wonderful legacy.

### Neville Gibbs MBBS, MD (UWA), FANZCA, MSc (Oxon)

#### Remembering Our Fellows

Our College acknowledges the life and career of Fellows that have passed away:

- Dr Victor Thompson White, WA, August 2021
- Dr Thomas Mackenzie Fiddes, NZ, September 2021
- Dr Gregory John Kesby, NSW, October 2021
- Dr James (Tim) Jeffery, WA, October 2021
- Dr Justin Frederick Nasser, Qld, November 2021